



RCMP PUBLIC COMPLAINTS COMMISSION

RCMP Act - Part VII
Subsection 45.46(3)

CHAIR'S FINAL REPORT

FOLLOWING A PUBLIC HEARING

Complainant:
Ms. Donna Wilson

March 31, 1998

File N°: 2000-PCC-950295

CHAIR'S FINAL REPORT FOLLOWING A PUBLIC HEARING

I. INTRODUCTION

The Process

Under subsection 45.43(1) of the *RCMP Act*, the Commission Chair, where she considers it advisable in the public interest, may institute a public hearing to inquire into a complaint whether or not it has been investigated, reported on or otherwise dealt with by the Force. The hearing is conducted by members of the Commission assigned by the Chair and, when completed, the Panel prepares an Interim Report setting out their findings and recommendations about the complaint. That report is sent to the Solicitor General of Canada, the RCMP Commissioner and to all parties and their counsel.

Upon receipt of the Interim Report, the RCMP Commissioner is required to review the complaint in light of the report's findings and recommendations. The Commissioner must then notify the Commission Chair of any further action that has been, or will be, taken with respect to the complaint or provide his reasons for not acting on any of the findings or recommendations.

After considering the Commissioner's Notice, the Commission Chair prepares a final report setting out such findings and recommendations with respect to the complaint as she sees fit. That report is also sent to the Solicitor General, the Commissioner and to all parties and their counsel.

The Interim Report and the Commissioner's Notice

The Interim Report dated January 31, 1997, a copy of which is attached hereto as Appendix "A", was sent to the Solicitor General, the Commissioner and has been forwarded to all parties. The Commissioner responded to the Interim Report by way of a letter to the Chair dated November 21, 1997 (the Commissioner's Notice), a copy of which is attached hereto as Appendix "B". The Interim Report includes a sufficient summary of the complaint and the evidence heard for the purposes of this Final Report.

It should be noted that the undersigned sat on the Panel that conducted the hearing into this complaint. Following the release of the Interim Report, I was appointed Commission Chair and, in that capacity, am now delivering the Final Report required by subsection 45.46 (3) of the *RCMP Act*.

II. FINDINGS AND RECOMMENDATIONS

Two general observations respecting the Commissioner's Notice are in order.

First, I am satisfied that my colleagues and I, on the Panel conducting the hearing, made every effort to bring the proper perspective to our review of the conduct in issue. We are aware that, frequently, officers must react quickly and make important decisions in less than optimum circumstances. Sometimes, however, and the subject case is an example, the circumstances in which the officer operates permits a relatively unhurried assessment of a situation. I believe the Commissioner's opening observation disregards the specific context of the conduct examined by the Panel. The evidence was clear that the members involved had no other pressing matters to divert their attention from Mr. Keddie.

Second, though I am very pleased with the Commissioner's response to the recommendations of the Panel, I am concerned by some of his comments on the findings that demonstrate a reluctance to defer to the view of the evidence taken by the Panel; unlike the Commissioner, we had an opportunity to consider the demeanour and credibility of all witnesses and to make a balanced assessment of the evidence. I note this concern and will comment no further on the subject.

Turning to the Commissioner's specific comments, I report as follows. In the interests of brevity, I have adopted the Commissioner's numbering and grouping of the findings and recommendations of the Panel:

Finding No. 1: The Commissioner agrees with this Finding so no further comment is necessary.

Findings No. 2 and 3: I have considered the comments of the Commissioner and reiterate the Findings of the Panel.

Finding No. 4: The Commissioner agrees with this Finding that no further comment is necessary.

Finding No. 5: I have considered the comments of the Commissioner and reiterate the Finding of the Panel.

Finding No. 6: I have considered the comments of the Commissioner and reiterate the Finding of the Panel.

Finding No. 7: I have considered the comments of the Commissioner and reiterate the Finding of the Panel.

Findings No. 8, 9, 10 and 11: The Commissioner agrees with these Findings so no further comment is necessary.

Finding No. 12: I have considered the comments of the Commissioner and reiterate the Finding of the Panel.

Findings No. 13, 14, 15, 16, 17, 18, 19, 20 and 21: The Commissioner agrees with these Findings so no further comment is necessary.

Recommendation No. 1: The Commissioner agrees with this Recommendation so no further comment is necessary.

Recommendations No. 2 and 3: The Commissioner has not specifically addressed the need for refresher training of the type recommended by the Panel and, therefore, I reiterate the Panel's Recommendations in this respect.

Recommendations No. 4 and 5: The Commissioner agrees with these Recommendations so no further comment is necessary.

Recommendation No. 6: I have considered the comments of the Commissioner and reiterate the Recommendation of the Panel. I agree with the Commissioner's statement that the evaluation of the risk must be left in the hands of the officer. However, the policy that is used as a guideline for the officer should state clearly that, when there is a risk, the officer should exercise his discretion on the side of caution and not place the intoxicated person with other detainees.

Recommendation No. 7: The Commissioner agrees with this Recommendation so no further comment is necessary.

Recommendation No. 8: The Commissioner's Notice only partially addresses the Commission's Recommendation. I, therefore, reiterate the Recommendation of the Panel.

Recommendation No. 9: The Commissioner states his agreement with this Recommendation. However, it is not clear whether this agreement includes a review by the RCMP of the items identified by the Panel as a. to f. I, therefore, reiterate the Recommendation of the Panel so no further comment is necessary.

Recommendation No. 10: I have considered the comments of the Commissioner and reiterate the Recommendation of the Panel. I should note that I see the Commissioner's comment on the need for a policy information system to be in place as a positive reply to the Recommendation and I accept his conclusion.

Recommendations No. 11 and 12: I have considered the comments of the Commissioner and reiterate these Recommendations of the Panel. I specifically reiterate that aspect of these Recommendations dealing with the dissemination and implementation of the Commission's Recommendations.

Recommendations No. 13 and 14: The Commissioner agrees with these Recommendations so no further comment is necessary.

Recommendations No. 15, 16 and 17: I have considered the comments of the Commissioner and reiterate these Recommendations of the Panel.

Before concluding this Final Report, I feel that I should point out, with considerable pride, how the complaint process has produced valuable results from the tragic death of Mr. Keddie. This would not have been possible without the commitment to the process evidenced by all participants. I would specifically like to commend Ms. Wilson, an ordinary citizen without any vested interest in the outcome, for the time and dignified effort she devoted to the complaint process. I also commend Constables Gibson, Parsons, Conrod and Edmonds, Corporal Hajash and Mr. Armstrong for their cooperative and forthright participation in a process that most certainly was not easy.

Further, I believe the Commissioner has acted, as shown by his Notice, in the thoughtful manner that the architects of the complaint process envisioned. As I understand it, senior officers of the RCMP have been in touch with Ms. Wilson following the release of the Interim Report and she has indicated her general satisfaction with their response to the recommendations made. Finally, I thank my colleagues on the Panel, Messrs. Wright and Bayly, for the wisdom they brought to the hearing process.

I believe, in this case, the public has been well served by the complaint process.

This is my final report to the Solicitor General and the Commissioner in relation to this complaint.


Chair

March 31, 1998

Shirley Heafey
Chair
RCMP Public Complaints Commission
P.O. Box 3423, Station "D"
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K1P 6L4

RCMP PUBLIC COMPLAINTS COMMISSION

RCMP Act - Part VII
Subsection 45.45(14)

COMMISSION INTERIM REPORT

Following a Public Hearing

Into the Complaints

of

Ms. Donna Wilson

PANEL

John L. Wright
John U. Bayly
Shirley Heafey

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RCMP PUBLIC COMPLAINTS COMMISSION

Royal Canadian Mounted Police Act

Part V11

Subsection 45.45(14)

COMMISSION REPORT

**Following a Public Hearing
Into the Complaint
of
Ms. Donna Wilson**

PANEL

John L. Wright,	Chair
John U. Bayly, Q.C.	Member
Shirley Heafey,	Member

**Hearing: held at Whitehorse in Yukon
March 4 - 9, 11, 12, 18, 19 and
May 2, 3, 1996**

**ROYAL CANADIAN MOUNTED POLICE
PUBLIC COMPLAINTS COMMISSION**

ROYAL CANADIAN MOUNTED POLICE ACT, 1986

IN THE MATTER of a complaint made by Ms. Donna Wilson concerning the conduct of Constables Kevin Gibson, T.C. Parsons, D.B. Conrod, G.D. Rook, Brian Edmonds, Corporal B. Hajash and Mr. Kenneth Armstrong in which the complainant alleges that:

On March 30, 1995 at the Whitehorse, Yukon RCMP Detachment, Mr. Robert Keddie died while in custody; he had been arrested at about 17:30 hours for being drunk; at the time of Mr. Keddie's arrest, police were told by at least three people that Mr. Keddie had seizures; Mr. Keddie was also known to have a medical alert tag around his neck and around his wrist.

Mr. Keddie should have been taken to and checked at the hospital before being lodged in the Detachment and, there, he should have been adequately supervised because of his known medical condition; the complainant says that many members of the public are very concerned about his death at the RCMP Detachment.

The named members and guard neglected their duties by failing to properly care for Mr. Keddie.

Heard at Whitehorse, Yukon, commencing on Monday, the 4th day of March, 1996.

COMMISSION REPORT

1. THE NOTICE OF DECISION TO INSTITUTE A HEARING

On October 19, 1995, the Chairman of the RCMP Public Complaints Commission gave notice of his decision made pursuant to subsection 45.43(1) of the *RCMP Act* to institute a public hearing into a complaint made by Ms. Donna Wilson. Pursuant to subsection 45.44(1), he named the member for the Yukon, Mr. John L. Wright, as Chairman, Mr. John U. Bayly, Q.C., and Ms. Shirley Heafey as members of the Commission who would hear the complaint. Where members of the Commission have been assigned to conduct a hearing, the members are deemed by subsection 45.45(1) of the Act to be The Commission.

On December 12, 1995, a Notice of Hearing scheduled for March 4, 1996 was issued and was subsequently served on Constables Kevin Gibson, T.C. Parsons, D.B. Conrod, G.D. Rook, Brian Edmonds, Corporal B. Hajash and Mr. Kenneth Armstrong.

2. PRELIMINARY MATTERS

There were two preliminary issues that were placed before the Commission by way of application.

The first issue was an application by the complainant, Ms. Donna Wilson, requesting that the Commission appoint counsel to assist her in the course of the hearing pursuant to subsection 45.45(5) of the *RCMP Act*. The ruling on this matter is attached to and forms Appendix "A" to this report.

The second issue was an application by Counsel for the RCMP Appropriate Officer to have the hearing into the matter adjourned pursuant to s. 23 of the Rules of Procedure. The issue on which this application was based was resolved to the satisfaction of Counsel for the Appropriate Officer prior to the start of the hearing. This application was therefore withdrawn by Counsel for the Appropriate Officer.

Two additional applications were made toward the end of the hearing by Counsel for the Force members, Mr. Horembala. He requested that the complaints against Constables Edmonds and Rook be dismissed for lack of evidence in implicating these officers in the complaint. Ms. Wilson and the other counsel all joined in the application. Following deliberations, the Commission panel made the following decision:

- a) it did not have the jurisdiction to alter the substance of the original complaint;
- and
- b) its jurisdiction was limited to making findings in its interim report only.

3. THE PROCESS

The public hearing began on March 4, 1996 and evidence was presented by Commission Counsel over the course of ten days from March 4 to March 19, 1996. At her request, the complainant, Ms. Donna Wilson, made her final submissions to the Commission on March 19, 1996. Counsel for the remaining parties made their final submissions on May 2nd and 3rd, 1996 when the Commission re-convened in Whitehorse for that purpose.

Between March 4 - 19, 1996, the Commission heard *viva voce* evidence from thirty-one witnesses. A number of these were eye witnesses to some of the events that formed the subject matter of the complaint. Others were called as expert witnesses to provide the Commission with a broader understanding of the medical, technical and policy issues raised. In addition to the *viva voce* evidence of those witnesses, the Commission received a book of exhibits which included reports and statements made by witnesses, as well as RCMP Policy documents and photographs. Numerous diagrams of the two sites related to the complaint (the Regina Hotel Lounge and the cell block area of the Whitehorse RCMP Detachment) were also received as exhibits.

During the first week of hearings, and with the consent of all parties, the Commission members, Ms. Wilson and counsel for the other parties visited the site of the Regina Hotel Lounge. Two visits were also made by all counsel, Ms. Wilson and the Commission to the Whitehorse RCMP Detachment to view the cell block area.

We have carefully considered all of the *viva voce* evidence together with the final submissions made by the complainant, Ms. Donna Wilson, and counsel for the other parties, and we reviewed the exhibits received in evidence. Our findings of fact and our recommendations to the Solicitor General of Canada and the Commissioner of the RCMP are incorporated into this report.

The complainant was not present on March 30, 1995 when the events that are the subject matter of this complaint occurred. Ms. Wilson made a complaint to the Commission because of her concern for the circumstances in which her friend Robert Keddie died while in the custody of the Whitehorse Detachment of the RCMP.

Ms. Wilson attended the entire hearing of the evidence and was a full participant in the hearing process. She made her final submissions on March 19, 1996, however, and

consented to counsel making their final submissions on May 2 and 3, 1996 in her absence since she was unable to be present on those days.

4. THE EVIDENCE: COMPLAINT #1

"At the time of Mr. Keddie's arrest, police were told by at least three people that Mr. Keddie had seizures; Mr. Keddie was also known to have a medical alert tag around his neck and around his wrist. Mr. Keddie should have been taken to and checked at the hospital before being lodged in the Detachment."

During the hearing it was indicated that Mr. Robert Keddie, the deceased, was a physically large 41-year old man known to friends, acquaintances and some RCMP members as a friendly and co-operative individual. Friends referred to him as "Basic Bob". In testimony, one friend described Mr. Keddie as "...a bush man. Long hair, beard and bush clothes," adding that, "He's always the same. Bob is just Bob. He was always the same. I never saw him mad, never actually anything."

From this and other evidence at the hearing, Mr. Keddie appears to have been a gentle man not known to be violent. This characterization is confirmed further by the evidence of two RCMP officers. Constable D. Rogers testified to his numerous dealings with Mr. Keddie in Dawson City, as did Corporal B. Hajash of the Whitehorse Detachment. Corporal Hajash said the following about one of his encounters with Mr. Keddie at a Whitehorse hotel:

"Yes. As a matter of fact, on one of my bar checks at the '98 Hotel, I believe I ran into Mr. Keddie and he reminded me that we had played hockey against each other in Dawson City. Whenever, I did a bar check and he was in the bar, there was a "Hello, how are you?, just general chit chat."

Mr. Keddie was also known to use and abuse alcohol and drugs. The evidence indicates that he had a serious medical condition brought on by excessive use of alcohol referred to as "grand mal" seizures. This condition had led to his having his motor vehicle operator's licence suspended by the Department of Community and Transportation Services. One witness, Ms. Mabel Jim, testified that she saw Mr. Keddie wearing a medic-alert tag on his wrist at some point during the year prior to his death.

The evidence in the hearing established that on March 30, 1995 Mr. Keddie had been consuming alcohol and liquid morphine during the hours prior to his incarceration.

The report of postmortem examination stated that the cause of death was, in fact, due to a combination of an acute morphine overdose and acute alcohol intoxication.

The hearsay testimony of Ms. Deborah Jean Green was that Mr. Keddle likely obtained the liquid morphine from his friend, Bob Taylor or "three fingers Bob" as his friends called him. Before he died, Mr. Taylor was Ms. Green's common-law spouse. He told her that he and Mr. Keddle had been together the day Mr. Keddle died and that he had given Mr. Keddle some morphine on that same day.

Ms. Green stated that the two men, Taylor and Keddle, had used morphine in the past. She had come home from work a number of times and found the two men "nodding off" in a way that was not, in her view, characteristic of having consumed too much alcohol. Ms. Green believed that they had likely obtained the morphine from a Mr. Tom Donovan. Mr. Donovan, who was a friend of Keddle and Taylor, had a prescription for liquid morphine to control his pain due to throat cancer. It was alleged that Mr. Donovan had given or sold some of the morphine to his friends from time to time. The Commission notes that both Mr. Taylor and Mr. Donovan died of morphine overdoses a few months after Mr. Keddle's death.

The events in Mr. Keddle's life during the hours prior to his being detained by police are not entirely clear. A friend of Mr. Keddle's, Ms. Lenea Cousins, testified that, on March 30, 1995, she found Mr. Keddle asleep in her room at the Capital Hotel shortly after 8 a.m. when she returned from her night shift as a bartender. Finding him there was not unusual as she frequently allowed him to stay there when he had no place else to go. Shortly upon her return to her room, Ms. Cousins went to sleep and awoke around 1:30 p.m. to find Mr. Keddle asleep. At that time, she woke him up and asked him to leave so that she could get ready for work. Mr. Keddle complied and left the room. Ms. Cousins said she was certain that Mr. Keddle could not have been drinking on the morning of March 30, 1995 because she believes he remained in her room while she slept and until she asked him to leave in the early afternoon.

On the other hand, another friend of Mr. Keddle's, Mr. Mel Watson, stated that he saw Mr. Keddle in the 98 Hotel around 9:30 a.m. on the day in question. Ms. Annie Remple, a bartender at the 98 Hotel, also testified that she served Mr. Keddle two glasses of beer at 9:30 a.m. on that same day.

According to the evidence, the next time Mr. Keddle was seen on that day was in mid-afternoon. Ms. Melanie Needham, testified that she saw Mr. Keddle around 3 p.m. on March 30, 1995 as he walked past the MacBride Museum where she works. He was with one of his friends whom she knew as "Chocolate Paul". Ms. Needham had been friends with Mr. Keddle since the mid-'80s when they both resided in Dawson City. She was aware that Mr. Keddle used soft drugs for recreational purposes but her view was that he was not a "hard core" drug user.

After spotting Mr. Keddle about 25 feet away walking on the street across from the Museum, Ms. Needham opened the door and called out to him to give him a message from his mother. Because Mr. Keddle often stayed at various places where there were no telephones, Ms. Needham's home was the "message centre" for Mr. Keddle's mother

to leave messages for her son. Mr. Keddie responded to Ms. Needham's greeting and asked her what his mother had wanted. She, in turn, told him to give his mother a call and he responded that he would do that. In her view and from her vantage point, Mr. Keddie, was walking and behaving in a normal manner though his voice sounded a little hoarse.

The evidence revealed that the next time that Mr. Keddie was seen on March 30, 1995, was around 5 p.m. near the front of the Regina Hotel. Mr. Mel Watson, and a man later identified as Mr. Malcolm Svrcek, were seen attempting to keep Mr. Keddie on his feet. There was a third unidentified man nearby who could have been Mr. Bob Taylor. The two men assisting and caring for Mr. Keddie lingered with him in front of the Regina Hotel for a few minutes while they tried to decide what to do with him.

In his testimony, Mr. Watson further described Mr. Keddie as " ... kind of stiffened up", lifting his legs high "like he was really putting a real big effort just to make a step". In response to defense counsel's question about whether he had ever seen a drunk person walk in that manner, Mr. Watson said "No". Mr. Watson added that he felt Mr. Keddie's condition was serious and "something more than just being drunk". Under further cross-examination, Mr. Watson reiterated that he felt that Mr. Keddie was in trouble and that there was something seriously wrong with him. He based his conclusion on the fact that he had seen Mr. Keddie drunk on other occasions and he did not seem drunk on this day.

After some time standing outside on the street, Mr. Watson and Mr. Svrcek decided that the closest place to take Mr. Keddie to sit down was the nearby Regina Hotel Lounge. With Mr. Keddie's arms draped over their shoulders, the two men supported him as they entered the Hotel and sat Mr. Keddie down at a table in the lounge. Mr. Svrcek left the premises and Mr. Watson stayed to keep watch over Mr. Keddie. On seeing the condition Mr. Keddie was in, the bartender, Ms. Leigh Storey, asked the men to remove him from the Hotel lounge. Ms. Storey testified that she assumed Mr. Keddie was very drunk because she noticed his legs were shaking and he looked dazed. It appears her request was ignored and Mr. Keddie remained at the table with Mr. Watson.

In the meantime, the delegated Watch Commander at the Whitehorse Detachment that day was Constable Kevin Gibson, a 14-year veteran of the Force. Constable Gibson was in uniform and had been patrolling the area around the Regina Hotel Lounge in a marked car at about 5 p.m. near the end of his shift. As he passed the Regina Hotel, Constable Gibson noticed three men directly outside the Hotel. One man (Mr. Keddie) was leaning against the car with two men (Mel Watson and Malcolm Svrcek) on either side of him. Constable Gibson testified that the two men "had a hand on his shoulder like they were shaking it or talking to him" adding that "something wasn't right." He drove around the block and back to the front of the Regina Hotel.

When Constable Gibson returned to the front of the Regina Hotel, he saw Mr. Keddie, with his arms draped over the shoulders of Mr. Watson and Mr. Svrcek, being assisted

into the Hotel. Constable Gibson states that, in his view, Mr. Keddie definitely looked intoxicated as he was wobbling on his legs. Constable Gibson then parked his car, called for assistance, and entered the Regina lounge.

On his way into the Hotel, Constable Gibson asked the bartender, Ms. Leigh Storey, if she had served Mr. Keddie any liquor to which she responded she had not. He then walked over to the table where Mr. Keddie was sitting with Mr. Watson. According to Constable Gibson, there was every indication that Mr. Keddie was quite intoxicated. His head was wavering back and forth and he was unable to communicate when Constable Gibson spoke to him.

In the absence of any further observation and additional information, the Commission believes it would have been reasonable for Constable Gibson to arrive at an initial conclusion that Mr. Keddie was simply intoxicated. However, evidence presented at the hearing indicates that Constable Gibson was told directly by several people that Mr. Keddie's condition was more than alcohol intoxication.

While Constable Gibson was making preliminary observations of Mr. Keddie's condition, he testified that Mr. Watson looked up at him and said something like "Leave him alone. Get out of here". Constable Gibson stated that he interpreted this as a confrontational move and decided he needed to establish his authority through the use of what he referred to as "verbal Judo". Consequently, he immediately told Mr. Watson to shut up or he would be going to jail too. Constable Gibson states that Mr. Watson immediately became co-operative and answered his questions.

When asked by the Commission panel to describe Mr. Watson's "verbally aggressive" conduct toward him, Constable Gibson confirmed that Mr. Watson never raised his voice nor did he get up from his chair during the entire incident. Constable Gibson's assessment of "verbally aggressive" conduct therefore is not borne out by his own testimony describing Mr. Watson's demeanor.

Mr. Watson, on the other hand, recalls having a brief conversation with Constable Gibson wherein he said words to the effect: "Just leave him alone. He's not drunk." then added "He's going through an episode". Mr. Watson was unsure of the precise words he used in warning Constable Gibson that Mr. Keddie was prone to seizures and heart attacks.

Nonetheless, Constable Gibson recalled being told about the seizures by Mr. Watson. Constable Gibson confirmed that, upon continued questioning by him, Mr. Watson indicated that Mr. Keddie was sick and that he had an "episode". Constable Gibson further testified that when he asked Mr. Watson what he meant by an "episode", Mr. Watson explained that Mr. Keddie was "prone to seizures and heart attacks". Constable Gibson confirmed that his response to Mr. Watson's explanation of Mr. Keddie's medical condition was: "He looks pissed to me." Mr. Watson did, at this time, acknowledge that Mr. Keddie had been drinking.

Constable Gibson testified that he asked Mr. Watson if Mr. Keddie was having a seizure or heart attack at that point. Mr. Watson repeatedly responded with a shrug of his shoulders. Constable Gibson interpreted the shrug to mean "no" and testified that he relied on this response as part of the basis for determining the condition of Mr. Keddie. However, Mr. Watson also testified that he was intimidated by Constable Gibson's warning and indicated that he did not want to say anything more for fear of going to jail.

In any event, Constable Gibson decided to take Mr. Keddie to jail instead of taking him for medical attention. Mr. Keddie was, therefore, removed for his own safety and because, in Constable Gibson's view, Mr. Keddie was drunk in a public place. The Commission panel was quite baffled by Constable Gibson's interpretation of a shrug. In North American society, a shrug of the shoulders has been universally accepted as meaning "I don't know" or "I don't care". The Oxford Dictionary describes a shrug as an expression of indifference, helplessness, contempt or vexation. Constable Gibson's own counsel, in his final submissions, acknowledged that he would not interpret a shrug of the shoulders as meaning "no". He suggested that Constable Gibson's interpretation might be construed as an error in judgment but insisted that this error should not be held against Constable Gibson unless it was viewed as gross misjudgment.

In light of the evidence, the Commission does view this error as serious misjudgment at best and at worst, an indication of his unwillingness to listen and pay attention to the information that he was receiving from Mr. Watson and others who knew Mr. Keddie.

It was about 5:30 p.m. on March 30, 1995 when a second officer, Constable T.C. Parsons, entered the Regina Hotel in response to Constable Gibson's call for assistance. Constable Parsons was on highway patrol and working the 8 a.m. to 6 p.m. shift. When he entered the Regina Hotel, he walked straight over to the table where Constable Gibson was standing near Mr. Keddie.

Constable Parsons had numerous dealings with Mr. Keddie prior to that day. These dealings consisted of half a dozen incidents of public intoxication and an arrest for impaired driving two weeks prior to this incident of March 30, 1995. He also recognized Mr. Watson sitting with Mr. Keddie and testified that, in his view, Mr. Watson was not drunk.

As he stood nearby, Constable Parsons recognized Mr. Keddie and said "Hi Bob". Mr. Keddie apparently responded with "Hey Natz". "Natz", as Constable Parsons explained, is a nickname that he was dubbed with by a friend some years ago. Constable Parsons did confirm that Mr. Keddie was so intoxicated he was unable to walk without assistance, lift a beer or stand alone. He further recalls observing Mr. Keddie's "usual watery, bloodshot eyes" while in the Hotel lounge. He could not, however, remember if Mr. Keddie's pupils were dilated or contracted. It must be noted, at this point, that Constable Parsons testified that he had voluntarily taken two RCMP seminars to learn to identify the symptoms that can be observed when trying to determine if someone is using narcotics.

The Commission is left to wonder why Constable Parsons did not make use of his acquired knowledge of the use of narcotics to observe Mr. Keddie when he assisted Constable Gibson in carrying out the investigation. Examination of Mr. Keddie's pupils could have given the officers an important bit of information that might have changed the course of events. However, even if Mr. Keddie had not survived that day, the citizens of Whitehorse could at least have the assurance that the necessary care had been provided.

Constable Parsons further testified that one patron, Desmond Smarch, who appeared to be very intoxicated, told him, in reference to Mr. Keddie: "He's had a heart attack". He responded to Mr. Smarch by suggesting that due to his intoxicated state, Mr. Smarch had better leave the Hotel or he too would be taken to jail.

In evidence given by Constable Parsons at the coroner's inquest and confirmed by him at the Commission hearing, Constable Parsons says that he was met with verbal abuse by some patrons in the Regina lounge and he described this in terms of patrons yelling at him that Mr. Keddie had a heart attack.

Another witness, Mr. Stan Gillingwater, testified that, after observing Mr. Keddie outside the Hotel, he had decided to go to the Hotel to see if there was something he could do to help. Once inside, he explains that he went to Mr. Keddie's table and spoke to him to find out what was going on. Based on his extensive first-aid training and his personal experience with people having seizures, Mr. Gillingwater stated that he did not think Mr. Keddie was drunk but rather that he looked like he was coming out of a seizure.

Mr. Gillingwater testified that he subsequently went over to speak to the second officer (Parsons) and told him he believed that Mr. Keddie had a seizure. Mr. Gillingwater testified that Constable Parsons responded by saying that he would see to it that Mr. Keddie got the attention needed and he (Mr. Gillingwater) should be quiet or he too would go to jail. Constable Parsons testified that he does not recall having a conversation with Mr. Gillingwater.

The Commission accepts that Mr. Gillingwater went to the table and spoke to Mr. Keddie to try to be helpful. However, the evidence is confusing and contradictory regarding the timing of the conversation that Mr. Gillingwater may have had with Constable Parsons. The Commission, therefore, is unable to accept this part of the testimony as conclusive evidence that Mr. Gillingwater and Constable Parsons did engage in a conversation. Notwithstanding, Constable Parsons did testify that he was informed by Mr. Smarch as well as a number of nameless patrons who yelled to him that Mr. Keddie had a heart attack.

Constable Parsons appeared to characterize these attempts by the patrons to inform him that Mr. Keddie was sick as verbal abuse. The Commission accepts the likelihood that some of the patrons may have used some colourful language in trying to get their

message across. Nevertheless, there is no doubt in the minds of Commission members that Constable Parsons was made aware of the possibility that there could be problems with Mr. Keddie's health, and that something could be more seriously wrong than alcohol intoxication.

The bartender at the Regina Hotel, Ms. Leigh Storey, testified that while the officers were at Mr. Keddie's table she was asked by a patron, Ms. Mabel Jim, to warn the officers that Mr. Keddie had just had a seizure. Ms. Jim had personal family experience with people having seizures and had extensive first-aid training. She knew Mr. Keddie, was aware of his medical condition and believed, from her vantage point, that he had a seizure. In Ms. Jim's view, Mr. Keddie looked bewildered and disoriented. He did not appear to know what was going on. Ms. Jim explained that she had seen Mr. Keddie drunk many times in the past and he had never been unable to walk. According to her, he had always managed to stand up and stagger out on his own.

Ms. Storey testified that following Ms. Jim's request that she inform the police officers of Mr. Keddie's health, she went over to Mr. Keddie, tapped him on the shoulder and told him he had to leave with the officers. Ms. Storey states that she then made eye contact with Constable Gibson and told him: "They are telling me he has had a seizure." She added that, "I think he heard me and his response was that he was drunk." Again, Constable Gibson apparently did not take this second warning seriously.

In further testimony, Ms. Storey estimated that there were about 25 people in the bar that day and characterized that number as "Not real busy". In describing the noise level and atmosphere of the bar on that afternoon, Ms. Storey said that it was just the usual "hum". Contrary to what Constables Gibson and Parsons indicated regarding the abusive attitude of Hotel patrons, Ms. Storey stated that when the RCMP came into the Hotel the noise level was a little lower and a little quieter. She confirmed that the entry of police into the bar usually has a calming effect. Ms. Storey added that, in her recollection, the bar did not get rowdier after the police entered.

Another witness, Mr. Philip Atkinson, who was in the Regina Hotel at the same time as Mr. Keddie, appeared before the Commission. Mr. Atkinson was serving a sentence at the Whitehorse Correctional Institute for breaching probation by communicating with his common-law wife at the time he gave his evidence. Although there were a number of questions that Mr. Atkinson could not respond to with absolute certainty, he was definite about two things: that Mr. Keddie was shaking all over when he was brought into the hotel; and that he did hear the bartender, Ms. Storey, say that Mr. Keddie had just had a seizure. A few minutes after Constable Parsons arrived at the Regina Hotel, he assisted Constable Gibson in removing Mr. Keddie from the Hotel. With their hands under Mr. Keddie's arms to support him, the two officers escorted Mr. Keddie out of the hotel and into the police car. It is clear that Mr. Keddie was being detained not because he was causing a disturbance but for public intoxication and to preserve his own safety and to maintain public peace pursuant to Section 87 of the Yukon Liquor Act.

In the police car on the drive to the Detachment, there was another detainee sitting next to Mr. Keddie. Testimony at the hearing indicated that Mr. Keddie apparently made a comment to his seatmate to the effect of, "Here we go again", indicating that Mr. Keddie had some awareness as to where he was.

On arrival at the Detachment, Mr. Keddie was assisted out of the car and taken into the booking area. Due to his level of incapacity, the two Constables laid Mr. Keddie out on the floor of the booking area rather than on a bench where he might have fallen off and injured himself. The two Constables then searched Mr. Keddie and made a list of his possessions. Contrary to evidence that Mr. Keddie had worn a Medic Alert tag at some point in the past, none was found on his person on that day.

During the time Mr. Keddie lay on the floor in the booking area, Constable Gibson testified that Mr. Keddie made a couple of attempts to sit up but complied when ordered by Constable Gibson to stay down. Constable Gibson also explained that Mr. Keddie opened his eyes when he tried to sit up but Constable Gibson did not make any observation regarding the condition of his eyes. Constable Gibson testified that he does not make note of the pupils of a person arrested for being grossly intoxicated. However, he indicated that he would make such an observation if a person were being investigated for impaired driving.

Mr. Keddie was subsequently dragged, for his own safety, to cell number 7 by Constables Gibson and Parsons. There, he was laid out on the floor of the cell facing the wall and in the company of other prisoners. Constable Gibson explained that he placed Mr. Keddie on his left-hand side with his hands in front of his chest area, his left leg was extended straight out, his right leg was cocked up and his hips were moved slightly forward onto his right leg. Constable Gibson referred to this manner of positioning Mr. Keddie as the "recovery position".

The complainant, Ms. Donna Wilson, in her final submissions, provided the Commission with a first-aid document that gives a detailed description of the recovery position. Ms. Wilson, a registered nursing assistant, noted that Constable Gibson's description of the recovery position was in conflict with the description provided in her document. According to the document, she is correct, in that the said person's arms should not be placed in the position as described by Constable Gibson. Given Ms. Wilson's evidence and Constable Gibson's admitted lack of updated training in first-aid, the Commission prefers Ms. Wilson's evidence on that point.

Following Mr. Keddie's placement in the cell, Constable Gibson went to the area where the cell guard, Mr. Ken Armstrong, was posted. Constable Gibson then filled out a prisoner report, a C-13 form, and confirmed that he told Mr. Armstrong to "keep an eye" on Mr. Keddie because he was prone to heart attacks and seizures. In addition, Constable Gibson circled and highlighted that particular comment in yellow on the form in an apparent attempt to alert the guard and the Watch Commander in charge of the next shift.

In the Commission's view, this confirms that Constable Gibson was clearly aware that the possibility existed that Mr. Keddie had a serious health problem and that he needed to be watched closely. From the evidence, this awareness could only have come from his being warned by Mr. Watson, Ms. Storey and possibly other patrons at the hotel calling out that Mr. Keddie was sick.

Prior to leaving the Detachment at the end of his shift, Constable Gibson had a brief discussion about the incident with Mr. Keddie with the Watch Commander of the incoming evening shift, Corporal Hajash, who began work shortly before 7 p.m.

The Corporal testified that he recalls being advised by Constable Gibson that they (Constables Gibson and Parsons) "had gotten a bit of a bad time or interference from the patrons" when they arrested Mr. Keddie and that Constable Gibson "was concerned about Mr. Keddie possibly having had a seizure or being prone to seizures".

Corporal Hajash agreed with a previous statement he had made to a Commission investigator in reference to his discussions with Constable Gibson at the shift change on March 30, 1995. He recalled Constable Gibson saying that patrons at the Hotel were "telling him that they shouldn't bother Mr. Keddie and that, ... they did tell him about seizures". Again, it is clear that Constable Gibson was well aware that this might not be someone who was just drunk.

Corporal Hajash also confirmed that it was his understanding that Constable Gibson was more concerned with the interference of Hotel patrons than with Mr. Keddie's seizures.

The Commission acknowledges the potential danger faced by police officers upon entering premises where his/her presence might elicit a hostile reaction and put his/her safety in jeopardy. However, there is no convincing evidence that this was the case at the Regina Hotel on March 30, 1995. The concerns expressed by Constable Gibson and Constable Parsons about the interference of patrons is not borne out by the overall evidence and particularly the evidence of the bartender, Ms. Storey, whose evidence is preferred by the Commission.

Expert evidence regarding the behaviour of persons suffering from addictions was presented to the Commission by Dr. B. Dickson who is a qualified and acknowledged expert in addiction medicine. He has a certification in Addiction Medicine from the American Society of Addiction Medicine; has carried out extensive research on chemical dependency; is an associate clinical professor at the University of British Columbia and has a private practice in Vancouver, B.C.

Dr. Dickson confirmed that if a person shows signs of intoxication such as unsteady walk, a strong odour of alcohol, slurred speech, and bloodshot, watery eyes that it is difficult to identify whether that person also has a potentially life threatening drug or alcohol overdose. He stated that, because an intoxicated person may have numerous

other problems such as a medical condition or drug overdose, it would be difficult to determine initially what the problem is "without some collateral information". Such "collateral information" could be, for example, someone indicating that this person had drunk a bottle of morphine or taken a shot of heroin. He stated: "... that information may make you suspect that this person is going to have a problem".

Constables Gibson and Parsons were not told that Mr. Keddie had drunk a bottle of morphine, however, they were told by a number of patrons that Mr. Keddie had a medical problem. Constable Gibson was told by, among others, Ms. Leigh Storey, a reliable person at the Hotel that day, that Mr. Keddie might be having a seizure.

Dr. Dickson explained that a person who has a history of seizures or has suffered a recent seizure should receive medical treatment. Without treatment, there is a risk that the person is "continually seizing" and can die as a result. There is also the potential for vomiting and aspiration of the vomit causing death. Dr. Dickson emphasized that seizures are a common withdrawal symptom in people who abuse alcohol and it can be toxic if it is not treated.

5. THE APPLICABLE LAW - SECTION 87 OF THE LIQUOR ACT

The Yukon Liquor Act provides at section 87:

87. (1) Where a peace officer has reasonable and probable grounds to believe and does believe that a person is in an intoxicated condition in a public place, the peace officer may, instead of charging the person under section 86, take the person into custody and deal with the person in accordance with this section.
- (2) A person taken into custody under this section shall not be held in custody for more than 12 hours after being taken into custody and shall be released from custody at any time if there are reasonable and probable grounds for the person responsible for his custody to believe that:
 - (a) the person in custody has recovered sufficient capacity that, if released, he or she is unlikely to cause injury to himself or herself or be a danger, nuisance or disturbance to others, or
 - (b) a person capable of doing so undertakes to take care of the person in custody upon his or her release.
- (3) No action lies against a peace officer or other person for anything done in good faith and without negligence with respect to taking into custody, holding in custody or releasing a person under this section.

- (4) Where a minor is taken into custody under this section, the peace officer who takes him or her into custody shall, as soon as practicable, make reasonable efforts to notify the minor's parents or an adult person who ordinarily has the care of the minor that the minor is in custody."

It is clear from this section of the Act that there is an intention to balance public safety with individual care and protection. The section is not penal, although it gives the police authority to arrest and confine in cells until sober, a person (including a minor), who appears to be intoxicated in a public place. We were told that during the year prior to the Commission hearing in March 1996 there were 3,839 arrests in Whitehorse. Of those, the number of alcohol-related arrests were 1,589 and included in that figure were 1,301 persons detained for being intoxicated contrary to section 87 of the Act.

1,589 arrests represents a significant part of the Whitehorse and area population as well as a significant part of the case workload of the members of the Whitehorse RCMP detachment. What is more, those people who come into contact with the law when arrested under section 87 include people, both known and unknown to the members and to the civilian guards. Some such people, no doubt, have problems, pathologies, medical histories and conditions unknown at the time to the RCMP. But the RCMP, by arresting them, become responsible on society's behalf for those people until they are sober enough to take care of themselves or until some responsible person agrees to take care of them.

It is apparent from reading the provisions of section 87 that part of the social objective of that section is to provide society with protection from dangerous intoxicated persons. But from a plain reading of the section, is the equally important objective to protect the personal well-being of people whose systems have been poisoned by the voluntary consumption of alcohol. There are many such people in Whitehorse, a fact that is confirmed by the booking records of the RCMP detachment and the statistics provided to us in Exhibit 26, the 1994 Yukon Health Status Report published by the Yukon Territorial Government. In Chapter 7 of that exhibit at page 59 (entitled Lifestyle Risk Factors), it states that there "was an increase in the percentage of current drinkers in the Yukon" between 1990 and 1993 and that "there was a decrease in the age of first use of alcohol in the Yukon" in the same period.

The above-mentioned report makes specific reference to the Whitehorse Detoxification Centre. In 1993-94, the Centre gave shelter and protection to 465 people, 88% of whom were male. Those people remained at the detoxification facility an average of 3.1 days.

In her evidence, Mary Plante, Acting Supervisor of the Whitehorse Detoxification Centre confirmed that the Centre does accept intoxicated persons suffering from alcohol or drug abuse provided they can communicate and stand up with little assistance and that the Centre will also care for such persons until and after they become sober. She also

indicated that when a person admitted to the Centre has a medical concern, such person would be sent to the hospital.

Unfortunately, only one of the officers of the Whitehorse RCMP detachment members who testified before us was aware of the existence of the Detoxification Centre, a rather remarkable fact given the relatively small size of the community.

In our view, it is essential that all serving members of the Whitehorse RCMP detachment be made aware of the location and services provided by the Detoxification Centre. As part of community policing, RCMP members should also be required, within their first week of duty, to visit the Detoxification Centre to introduce themselves and to become personally familiar with the services it offers. This requirement should extend to Watch Commanders and all non-commissioned officers (NCOs) involved in any way in community policing in the City of Whitehorse and its surroundings.

Although alcoholism is recognized as an illness, the acknowledgment of this fact is slow in coming in some quarters. Those people whose contact with the law is as a result of public intoxication, often require care of a type not available in a police lock-up. Often they are not able to care for themselves. Although taken into custody in part for their own protection, they may be at risk because of their condition and because of the behaviour of other prisoners. The Commission is aware of this; having heard evidence of the abuse of one intoxicated prisoner by another in the Robinson/Farewell complaint hearing in 1989.

We believe the RCMP has a duty under Section 87 of *the Liquor Act* to arrest people found intoxicated in public. But, contrary to Sergeant Payne's view that the detachment is not a medical facility, the Commission believes that when police have the care of intoxicated persons for a period of up to 12 hours in their cells, the detachment should indeed be regarded as a quasi-medical facility, in that, the lives, health and safety of the prisoners are in their hands and training should be at a corresponding level.

The same Yukon Government which passed *The Liquor Act* also provides for the care of intoxicated persons at the publicly funded Whitehorse Detoxification Centre. But the "responsible person" in charge of the detoxification centre can only undertake to look after people already in police custody if a peace officer informs that responsible person of the arrest and gives that responsible person the option of whether or not to undertake the care of the intoxicated person in police custody.

In many cases, it would be an easy thing for the arresting officer or the telecommunications operator to contact the Detoxification Centre and, if space is available, to deliver the arrested person to the care of the detoxification personnel. No doubt there will be intoxicated people arrested whom it would be inappropriate to take to the Detoxification Centre. Those whose drunken behaviour is violent, those who are apparently injured or those arrested not only under section 87 of *the Liquor Act* but for other reasons, should obviously not be taken to the Detoxification Centre. However, in

our view, Mr. Keddie could have been taken somewhere other than to the police cells in the Whitehorse detachment.

It is our view that Mr. Keddie should have been taken either to the Detoxification Centre or to the hospital. On the evidence before us we cannot say that had Mr. Keddie been taken to the hospital or the Detoxification Centre, his life would have been saved. However, from the evidence at the hearing, the two arresting officers did not have any pressing police emergencies to which they were required to respond nor was their safety in jeopardy. Mr. Keddie was successfully removed from the hotel. There is, therefore, no compelling evidence to indicate that the two constables did not have the time and resources to consider a wider spectrum of possibilities as to where to take Mr. Keddie once they took him out of the bar. They had the opportunity to consider the information that was given to them about Mr. Keddie inside the hotel and give it the attention it deserved. They had the time for a trip to the hospital, but this was apparently not considered.

The evidence indicates, that Constable Gibson made up his mind that Mr. Keddie was drunk and that he was going to take him to jail. His focus appears to have excluded the possibility that Mr. Keddie had a health problem requiring immediate medical attention. The irony of this decision is that Constable Gibson testified that (a) when he is in doubt about a prisoner's condition, he errs on the side of caution; and, (b) that his knowledge of seizures is limited to the following: "If he wasn't on the ground convulsing, I would have to take the person's word for it that he'd had one, if he was sitting in a chair, because I don't know any other symptoms." On March 30, 1995 Constable Gibson did not err on the side of caution nor did he take the word of Mr. Keddie's friends regarding his seizures and his possible heart condition.

In addition, Constable Gibson did something that was described by some witnesses as somewhat unusual in completing the prisoner report on Mr. Keddie on the evening of March 30, 1995. He wrote a comment made to him by many of Mr. Keddie's friends at the Regina Hotel that evening to the effect that Mr. Keddie was prone to seizures. He then highlighted the comment in yellow and put an asterisk next to it. This indicates to us that he was clearly aware of concerns expressed about Mr. Keddie's health and, in our view, chose to ignore the warnings and the signs and did not take Mr. Keddie for medical treatment. We regard Constable Gibson's evidence as confusing and inconsistent. We also consider that he demonstrated very poor judgment in carrying out his duties on the evening of March 30, 1995.

The evidence of Constable D.F. Rogers of the Watson Lake Detachment provided a stark contrast to the Whitehorse Detachment. Constable Rogers was a five-year veteran of the RCMP at the time of the Commission hearing. He was familiar with Mr. Keddie from three encounters they had with him related to his intoxication. One of these was a prior occasion when Constable Rogers detained Mr. Keddie for impaired driving. He explained that Mr. Keddie was coherent and standing on his own in spite of an extraordinarily high reading of 310 milligrams per 100 millilitres of blood. Constable

Rogers stated that, as a result of the reading, he decided to keep Mr. Keddie in custody after determining that there was no one who could care for him in a responsible manner to ensure his safety. A C-13 (prisoner report) was filled out and a notation was made stating that the guard should make close checks on Mr. Keddie. This was because of an anonymous call made to the Watson Lake detachment alerting the police that Mr. Keddie had a medical problem. Mr. Keddie was coherent and walking entirely on his own on this prior occasion, yet the care he was afforded by the Watson Lake detachment, in our view, was much higher than that of the Whitehorse detachment on March 30, 1995 when Mr. Keddie was unable to communicate and incapable of walking on his own.

Constable Rogers also testified that the Watson Lake Detachment has a book which he referred to as a duo-tang folder in which is kept information about high risk prisoners who often come to the attention of the police. Names of people like Mr. Keddie who are chronic alcoholics would be noted in this book indicating any known problems they may have which might assist a police officer in dealing with her/him including a health problem or tendencies to violence, etc. Constable Rogers explained that this was a system set up in Watson Lake in an effort to supplement the limited information that is found on a C-13. In our view, this is a commendable initiative on the part of this detachment in trying to fill a policy void that obviously exists regarding the availability of vital information to assist members of the detachment.

The RCMP may be concerned that matters touching on the custody of a person should not be turned over to civilian agencies. But that, in our view, should not be a concern. In the first place, the RCMP already delegates the care of intoxicated people to civilian guards with minimal training as in the case of Mr. Ken Armstrong and the care of Robert Keddie. In other detachments, private security companies provide all of the security services and prisoner care within the detachment cell block. If such responsibility for people charged with criminal offenses can be so delegated, the delegation (authorized by s. 87(2)(b) of the *Liquor Act*) of responsibility for intoxicated persons should not be a major impediment for the RCMP.

Furthermore, the more of those sorts of tasks that can be delegated to some other agencies or provided under contract, the more RCMP members can focus their energies on the other duties they are specially trained and sworn to do.

6. POLICY AND TRAINING

On the question of training, the Commission had the evidence of the named officers themselves. We also had the evidence of Sergeant Thomas Edwin Payne, the Operational NCO at the Whitehorse Detachment. He has been a sergeant for seven years and has spent the past four years in Whitehorse. As Operational NCO, Sgt. Payne is responsible for dealing with the Force members who are actually on the street, administering the law. Sergeant Payne's duties as an Operational NCO include responsibility for overseeing four shifts as well as the Highway Patrol unit, each of which

have a senior officer or an NCO in charge of individual units. These units are his full responsibility from a policy and compliance perspective.

During the hearing, Constable Gibson testified that he was unaware of the RCMP policy regarding first-aid training and re-certification. Indeed, his first-aid certification was not up to date and had lapsed some years prior to the March 30, 1995 incident. RCMP policy is clear that it is mandatory that all operational personnel maintain their First Aid/CPR certificate and that a refresher course be taken every three years. There are also RCMP directives regarding what members are to look for regarding medical symptoms that are common in the case of chronic alcoholics.

Constables Gibson and Parsons both indicated that they were aware of the three levels of Force policy, namely, the "white" "green" and "pink" sheets. They considered that the "pink" sheets were of prime importance because they directly related to the Whitehorse detachment, however, both testified that there was no system in place to ensure that members actually read bulletins with updates and changes in policy. Constable Gibson testified that it had been a number of years since he had read section E.3. entitled "Medical Treatment" in headquarters policy and he was unaware that there had been a change since June 1995.

Both Constables Gibson and Parsons' respective interpretation of vital terminology used in the "Medical Treatment" section of the headquarters policy varied significantly from each other and from that of RCMP policy witness, Sergeant Payne. None of the Force members who testified were aware of the Robinson/Farewell report in which the Commission had made recommendations with respect to dealing with illness and the care of intoxicated persons. In our view, the inconsistencies in interpretation and application of relevant policy touching directly on the member witnesses' duties in Whitehorse can only lead to future problems in this detachment.

Officers appear to be left to their own devices to read or not read bulletins, updates and changes in policy that could directly affect their day-to-day dealing with the citizens of Whitehorse. There also appears to be no requirement to update general or specialized training and no evidence at the hearing indicated that the members of the Whitehorse detachment have been trained to deal with the problem of alcohol and drug abusers. Since this is an issue that constitutes a significant problem in Whitehorse as revealed by the statistical evidence given at the Commission hearing, it is surprising that these deficiencies have not led to more frequent problems of the nature being dealt with by this Commission panel.

The evidence at the hearing not only revealed that there is too much policy to read and to keep abreast of, but also that it is contradictory and confusing at the national, divisional and detachment levels with regard to the assistance it gives officers who must decide when to take a prisoner to a doctor or a hospital. Witnesses revealed different interpretations of what state of consciousness a person under arrest would have to be in to be considered in danger and therefore requiring medical care. It must be equally

perplexing for the constables charged with taking intoxicated persons out of harm's way not to have a clear Force-wide understanding of this important and vital issue.

Given the large number of alcohol-related arrests each year in Whitehorse, it is difficult for the Commission to avoid questioning how the Force members could continue efficiently carrying out their sworn duties with their apparent limited training and in the absence of policy and community awareness. It is unfair to officers themselves who are not equipped to properly deal with the variety of problems that arise related to alcohol and drug abuse. It is also an unacceptable situation for the citizens of Whitehorse.

On the issue of policy and training, the Commission panel heard evidence from Constable Bruce Troche of the Brandon, Manitoba police force. He testified about the difficulties that the Brandon, Manitoba police force experienced some years ago regarding the maintenance and uniformity of policy and training standards of its police officers. The deterioration of its own standards and management led the City of Brandon to become a member of the Commission on Accreditation for Law Enforcement Agencies (CALEA).

CALEA is an American policing standards organization which sets independent standards to which member police forces agree to subscribe. Constable Troche was trained as a Professional Standards Audit Unit Accreditation Manager for the Brandon force. He explained in detail the self-auditing system in place to ensure that the Brandon force meets independent international standards. The details can be examined in the transcript of the evidence.

Whether the RCMP needs to be part of CALEA or whether it is capable of setting and, through self-audit, maintaining its own acceptable standards, is not a question for us to answer. However, the treatment and care of Robert Keddle while in RCMP custody left Commission members with serious concerns regarding RCMP policy and procedure and the implementation of both at the detachment level in Whitehorse.

According to Sgt. Payne, no one appears to be expected to know policy. The view expressed repeatedly throughout the hearing is that there is too much of it in the RCMP. It is scattered through materials available to RCMP officers and is sometimes taken out of circulation altogether for periods of time. Canadians believe that the RCMP is the best national police force in the world. The Commission, speaking for the interested and concerned public, hopes it is so. But how do we know? What are the comparative standards? How does the RCMP conduct self-examination?

None of that was clear to us in this hearing. At a micro-level, there is no evidence that the RCMP had, after Robert Keddle's death, examined policy, training, response, facilities or record-keeping to determine whether there might have been ways of dealing with such situations differently or better or at earlier stages so that in future situations, the policing decisions and responses can be improved upon. On the contrary, Sgt.

Payne's evidence indicated that a very cursory and routine examination of the file was done and then the matter was closed. In our view, a death that occurs in police cells is not routine and such an incident should be scrutinized more assiduously by the RCMP.

There are many questions which the Force can explore to maintain the high standards for which it has been recognized world-wide. Issues such as the appropriate standards for the care and custody of prisoners, for the facilities in which they are imprisoned, and for training and conduct of those who arrest and look after them should be dealt with. Clearly defined policies to guide members and civilian employees of the RCMP should be developed and readily available to all personnel.

An example of an unclear policy was given by Dr. Gordon B. Dickson, an expert in addiction medicine. He testified as to his concerns about the clarity of RCMP policy E.3.a. dealing with medical treatment. The policy clearly states that if there is any indication that a person in custody is ill, suspected of acute alcohol poisoning or a drug overdose, or is injured or not fully conscious, he/she should receive medical attention. However, there is no definition of acute alcohol poisoning, drug overdose, etc. How is a police officer to identify any of these symptoms if he/she has no definition, and no guidelines to rely on? The question is left wide open and any decision made by a police officer will be very arbitrary. Some standard setting and monitoring is lacking in the RCMP. Quite frankly, in the tragic circumstances surrounding the death of Robert Keddie, it showed.

Mr. Wayne Jeffrey, a pharmacist and certified drug recognition expert, testified about a program that was started in the United States to train police officers to detect impairment either by alcohol or by the combined effect of alcohol and drugs or by drugs alone. This type of training program would provide a police officer with skills that would prepare her/him to face these problems with confidence and efficiency. Whether or not the RCMP takes part in this specific program is not for us to say. We strongly urge, however, that the Force explore the options available in this field of training in order to prevent further tragedies. Unquestionably, Force members should also become aware of the resources available in the community that could assist them to do their job more efficiently and safely. We wish to emphasize that a good knowledge of the community the Force members are policing is the minimum that the City of Whitehorse has a right to expect.

The Commission is aware that policing has taken a very positive turn toward the concept of community policing in the past few years. This means that there is an increasing reliance on the community to participate in making their cities and towns safer and more law abiding places in which to live. The RCMP has been involved in this initiative. The problem of alcohol and drug abuse, like many other problems in our society, must be dealt with by the entire community. The actions of police in dealing with people who are so impaired by alcohol or drugs and who present a threat to themselves and others, must form part of the community's overall strategy in these matters.

Community policing is self-explanatory. In this instance, it is the community working together to deal with drug and alcohol abuse. It is not and should not be a police initiative only. The Force must promote, encourage and welcome community participation because it is the key to effective policing.

In the case at hand, the bartender, the hospital, the patrons (those who were trying to be of some assistance), friends of Mr. Keddie, the Detoxification Centre and potentially a number of others comprise those parts of the community that could have maximized the potential for dealing with Mr. Keddie's problem in a more constructive manner. All of society, and particularly the more vulnerable members of our communities like Mr. Keddie, is at risk when the police and the community do not work together to make the system work.

7. FINDINGS AS TO THE CONDUCT OF THE NAMED OFFICERS AND THE APPROPRIATENESS OF THEIR ACTIONS IN THIS FIRST COMPLAINT

Finding #1

There is a conflict in the testimony of three witnesses regarding Mr. Keddie's whereabouts between 9 a.m. and 1:30 a.m. on March 30, 1995. However, having regard to the overall evidence on this issue, the Commission finds that Mr. Keddie was drinking in the 98 Hotel the morning of March 30, 1995 and that Ms. Cousins was mistaken in making an assumption that Mr. Keddie remained in her room while she slept.

Finding #2

The Commission finds that there were definite indicators that Robert Keddie was ill and that the arresting officer, Constable Gibson, ignored them, minimized them and in spite of the evidence failed to take Mr. Keddie for medical attention.

Finding #3

The Commission finds that there were definite indicators that Robert Keddie was ill and that the assisting officer, Constable Parsons, failed to consider them and equally failed to consider his prior knowledge of Mr. Keddie which could have shed more light on the situation and allowed other options, other than lodging Mr. Keddie in a cell, to be considered.

Finding #4

The Commission finds that there was no evidence that Robert Keddie was wearing a medic-alert tag at the time of his arrest.

Finding #5

The Commission finds that the evidence did not reveal the existence of conclusive indicators that could have led Constables Gibson and Parsons to specifically suspect that Mr. Keddie was the victim of a drug overdose. Constable Gibson's failure to note indicators of a drug overdose could also be a result of his lack of training in this area. Constable Parsons, who had training in making observations and recognizing indicators of drug abuse or overdose, failed to apply that training in this situation.

Finding #6

The Commission finds that the evidence does reveal the existence of indicators that could have led Constables Gibson and Parsons to suspect acute alcohol poisoning.

Finding #7

The Commission finds that there were definite indications that Robert Keddie was not fully conscious and consequently should have been taken to hospital.

Finding #8

The Commission finds that Constable Gibson did not have sufficient first-aid training and particularly, that neither Constables Gibson nor Parsons had sufficient knowledge and training in the handling of intoxicated people to be able to implement the RCMP's policy, even though said policy was ill-defined.

For the most part, the Commission was left with the clear impression that the considerations outlined in the policy directives appear to have been unknown, ignored, not understood or forgotten by Constables Gibson and Parsons.

Finding #9

The Commission finds that the prisoner report, the C-13 form, and bulk file system for intoxicated persons is inadequate. The Commission was left with the impression that the bulk file is not a priority insofar as giving it the care and attention that other files receive. It is known as the "drunk" file and the people whose names appear repeatedly in those files do not appear to be treated with the same importance as those in the regular files. In our view, this is totally unacceptable and should be reviewed by the RCMP.

Finding #10

The Commission finds that the Whitehorse detachment does not have adequate methods to ensure that policy is both read and understood by its members. Nor does it have adequate checks and balances to ensure that policy is properly, efficiently and consistently reviewed and implemented by its members.

Finding #11

The Commission finds that the members of the Whitehorse detachment do not have adequate policy training and are not provided with guidance to allow them to carry out their policing duties safely.

8. THE EVIDENCE: COMPLAINT #2

"Mr. Keddie should have been taken to and checked at the hospital before being lodged in the Detachment and, there, he should have been adequately supervised because of his known medical condition."

This complaint involves Corporal B. Hajash, Constables D.B. Conrod, G.D. Rook, Brian Edmonds and the cell guard Mr. Kenneth Armstrong.

Corporal Hajash was the Watch Commander on the evening shift which began at 7 p.m. on March 30, 1995. At the start of his shift, Corporal Hajash conferred with Constable Gibson regarding the prisoners lodged in the detachment cells. Part of the discussion between the two officers involved Mr. Keddie. Constable Gibson made Corporal Hajash aware that, when he removed Mr. Keddie from the Regina Hotel, he was told by Hotel patrons that Mr. Keddie was sick and that he was prone to seizures and heart attacks.

Corporal Hajash testified that he was quite familiar with Mr. Keddie. He had had numerous encounters with him dating back to when he was stationed in Dawson City. He knew Mr. Keddie had a tendency to drink and drive and that he had quite a drinking problem. Corporal Hajash also knew from personal experience on a prior occasion that Mr. Keddie had appeared to be what he described as fairly normal after an extraordinarily high breathalyzer reading of 230. On that occasion he observed that with that much alcohol in his system, Mr. Keddie was not staggering or falling down drunk and was able to communicate and walk on his own.

Given the personal knowledge that Corporal Hajash had of Mr. Keddie, the observation he made of Mr. Keddie passed out in cell #7 along with the potential health problem highlighted to him by Constable Gibson at the start of his shift as Watch Commander, the Commission panel cannot avoid noting Corporal Hajash's complacency, lack of awareness and alertness vis-à-vis his responsibility for the treatment of a prisoner in his care.

No evidence was adduced with respect to whether or not Corporal Hajash alerted his colleagues of Mr. Keddie's potential health problem before he left the Detachment to go home for lunch on March 30, 1995. That would obviously have been the proper procedure to follow.

The cell guard on duty under Corporal Hajash's command on March 30, 1995 was Mr. Ken Armstrong. Mr. Armstrong is a long-time resident of Whitehorse and a retired Canadian Airlines employee who had worked for 23 years as a ground maintenance employee, loading and unloading aircraft. Mr. Armstrong did have a first-aid certificate with some CPR training which was a pre-requisite to be considered for employment as a jail guard by the RCMP.

Mr. Armstrong was hired and started work in January 1994. He underwent a 4-hour training program prior to commencing his duties. He was trained to do the required paperwork while he was on duty. This included maintaining the log book of cell activities, and how to guard prisoners. He testified that he received no training in identifying and treating alcohol poisoning or in identifying seizures. Again, the Commission panel regards the lack of training in this area as irregular and unacceptable for a guard whose duties involve, in large part, watching over intoxicated persons in the "drunk tank" and ensuring their safety.

Mr. Armstrong's first two shifts on guard duty were supervised. After his second shift, he began guarding prisoners alone on February 20, 1994. He testified that he was instructed to visually check prisoners by going right up to the door of every cell that was occupied. The purpose of this check was to ensure that prisoners were breathing and that all was normal. Mr. Armstrong testified that he determined if a prisoner was breathing by observing the stomach or chest movements of the person. He was further told to check to see if prisoners were throwing up or trying to harm themselves. Mr. Armstrong added that he was aware that the RCMP policy required him to check prisoners along the continuum anywhere from "continuously" to every 15 minutes. Mr. Armstrong was further instructed to note the position and change of position of prisoners in the cell, and any entry or exit of prisoners and members in the cells according to the time of occurrence. In testimony, he agreed that the guard room log is to be kept to note periodic checks of prisoners, incarceration of new prisoners, release of prisoners, visits, medical treatment and interviews with legal counsel so that a reliable record is available to refer back to at all times. It is the Watch Commander's duty to review the log book periodically when he inspects the guard room to ensure its accuracy.

With respect to prisoner checks, our own observations in the guardroom and cell block area revealed that it was impossible to properly view prisoners without going to the cell doors, that it was impossible to hear prisoners if the door between the guardroom and the cell corridor was closed and that it would be impossible to observe whether a person were breathing normally without entering the prisoner's cell itself, particularly if the prisoner's face was turned away from the cell door. Any observations of prisoners recorded as cell log entries, considering our observations of the sight and hearing limitations in the guardroom complex, would be suspect if they were not taken in close proximity to the prisoners. Mr. Armstrong testified that he was not aware of a Whitehorse policy manual containing pink sheets until April 7, 1995 when he read it for the first time and signed to the effect that he had reviewed it. He had, however, read

that part of the white sheets dealing with guard duties in the cell block when he began work as a guard in 1994.

Mr. Armstrong stated that upon Mr. Keddie's arrival at the detachment with the two constables, he opened the door to the secure bay for them. He recognized one of the prisoners as Mr. Craig Cox. The log indicates that Mr. Cox was placed in cell #7, however, Mr. Armstrong said that was a mistake. In fact, Mr. Cox was lodged in Cell #3. Mr. Armstrong could not provide a suitable explanation for this discrepancy in the log.

Mr. Keddie was, in turn, taken into the cell block area and processed by Constables Gibson and Parsons. Mr. Armstrong described Mr. Keddie as looking very intoxicated because of the sluggish movements of his head and arms. He indicated that, in his view, Mr. Keddie was still conscious but unable to walk. Mr. Armstrong further indicated that Mr. Keddie's eyes did not open as he was being slid into the cell. Furthermore, he appeared limp almost to the point of being passed out.

Minutes after Mr. Keddie was placed in a cell, Constable Gibson stood at the guardroom counter and filled out a C-13 prisoner report. On the C-13 he made a special notation indicating that a friend said that Mr. Keddie was prone to seizures. This comment was highlighted with an asterisk and with a yellow marker on the report. Mr. Armstrong testified that Constable Gibson told him "that friends had told him that Mr. Keddie was prone to seizures and to watch him closely." To Mr. Armstrong, "watch him closely" meant to watch Mr. Keddie anywhere from two to fifteen minutes and to record his observations in the log book. In contrast, Constable Rogers of Watson Lake testified that close checks in his detachment were carried out every five minutes.

Mr. Armstrong was questioned by Commission counsel about the recorded checks in the log book while he was on duty on March 30, 1995. It was pointed out to him that the recorded checks did not range from two to fifteen minutes as he earlier indicated but rather they ranged from 20 minutes to 105 minutes. When asked to explain this anomaly, Mr. Armstrong stated that he checked Mr. Keddie much more frequently than what he indicated in the log book. He was unable to provide an explanation for not having recorded the numerous other times he states he checked Mr. Keddie. At 23:10 on March 30, 1995, Mr. Armstrong observed Mr. Keddie lying in the cell and he could neither see nor hear any sign of breathing. Alarmed at this observation, he testified that he, nonetheless, stopped and took the time to record his observation in the log book and then telephoned Constable Conrod for help. The RCMP policy guidelines call for him to ring the cell block alarm immediately to alert his superiors in an emergency. In our view, a prisoner who has apparently stopped breathing is an emergency. His explanation for not following policy on this occasion was that he did not want to disturb the other prisoners.

In the absence of Corporal Hajash, Constable Conrod was the senior officer present in the Detachment on the evening of March 30, 1995. He had been a member of the

RCMP for about 13 years and had spent about two and a half years in Whitehorse at that time.

Constable Conrod's testimony revealed that, shortly after 11 p.m. on March 30, 1995, he received the first telephone call from Mr. Armstrong informing him that he wasn't sure that one of the prisoners was breathing. Constable Conrod stated that he instructed Mr. Armstrong to go into the cell to check the prisoner more closely and report back with his findings. Constable Conrod indicated he knew that he was asking Mr. Armstrong to go into the cell alone and that RCMP policy did not allow guards to go into cells alone for safety reasons.

Mr. Armstrong did go into the cell as he was ordered to do and within minutes, called Constable Conrod again to confirm that Mr. Keddie was not breathing. Constable Conrod asked Constable Rook to accompany him and they both ran to the cell block. On arrival in the cell area, Constable Conrod rang the door buzzer and Mr. Armstrong let the two officers in. Constable Conrod then proceeded to Mr. Keddie's cell and he and Constable Rook examined Mr. Keddie.

Constable Rook testified that he realized he had to start first-aid immediately as soon as he saw Mr. Keddie. He retrieved plastic gloves from a nearby box to prepare to start resuscitation. He and Constable Conrod decided it best to move Mr. Keddie outside the cell because there were other prisoners in the cell and not enough room to properly administer CPR. They indicated that they were also concerned about Mr. Keddie's and their safety. Constable Rook and Constable Conrod quickly dragged Mr. Keddie outside the cell area and both officers commenced two-man CPR. Mr. Keddie did not respond to these continued resuscitation efforts. The ambulance arrived while Constable Rook continued administering CPR all the way to the hospital where he remained until resuscitation efforts ceased.

Another officer on duty at the detachment on that evening was Constable Edmonds. He attended in the cell area after hearing Constable Conrod's voice over the radio requesting the presence of Corporal Hajash, the coroner and Staff Sgt. Williams in the guardroom. He observed Constables Conrod and Rook and ambulance attendants caring for Mr. Keddie and then carrying him away in the ambulance. Constable Edmonds subsequently took photographs of liquid deposits on the floor of the guardroom where Mr. Keddie had lain. He also attended at the Whitehorse General Hospital to take further photographs of Mr. Keddie and to deliver the required forms to be filled out by Hospital officials. This was the extent of Constable Edmonds' involvement in the events leading to Mr. Keddie's death.

During the Commission hearing, Constable Conrod was questioned regarding the requirement to keep current with policy at the Whitehorse detachment. He testified that there was a reading basket in the office for the members but the onus was on the members to peruse the material. He also indicated that he was not in the habit of checking the pink sheets (detachment policy) on a regular basis because he is more

concerned with his own police work and his investigation of files. Constable Conrod's testimony demonstrated the same casual attitude toward knowing, understanding and following operational policy as did all of the Force witnesses at the Whitehorse Detachment. This may be due, in part, to what appears to be a casual approach to policy by superiors responsible for ensuring accountability in this area.

9. POLICY AND TRAINING

During the hearing, the Commission was amazed at the insufficiency of training and lack of vital knowledge that the RCMP witnesses demonstrated through their testimony including the members who were not named in the complaint.

Mr. Ken Armstrong, the civilian guard, testified that most of his training with respect to the making of entries in the cell log was on the job. Mr. Armstrong's record keeping was at best inconsistent and unreliable since he himself indicated more checks were made on Mr. Keddie than he recorded. We find we cannot rely on the log book as a record of what went on in cells on the night of Mr. Keddie's death, save where it is corroborated by other credible evidence.

Keeping a log is an important task. It takes care and time to be done correctly. Logging events distracts the recorder from other tasks. The keeping of the cell log cannot be done while observations are being made or other tasks performed.

We agree good records must be kept of the activities and important observations made by guards on watch having responsibility for prisoners. However, other ways may have to be found to keep track of and record important information while tasks are being performed. For instance, the use of a voice activated recording system with independent time keeping capabilities may be a partial solution. So may a second person on watch, or a closed circuit television monitoring of each cell in the block. Just as important as having the tools and enough staff to use them, however, is having a system of recording which ensures that certain basic information is always recorded. Such information should include:

1. the taking of prisoners to and removing them from cells;
2. the entry into the cell area or into a cell by a police officer or other person not in custody;
3. the time of routine and specific checks; and
4. the recording of significant observations, the nature of which should be a matter of policy.

With respect to the last point, proper training must be provided to civilian personnel working as guards as well as to police officers in the RCMP. That training may be available through Corrections Canada if it is not available through the RCMP.

In another report of this Commission (Robinson/Farewell), the Commission panel made its views known to the RCMP and to the public about the importance of keeping an accurate and uncompromised cell log. In the Robinson/Farewell case, the removal from and replacement of an intoxicated prisoner into the Gibson detachment drunk tank was not recorded in the cell/prisoner log.

We were disappointed to learn that Sgt. Payne, the policy witness put forward by the appropriate officer in this case, was unaware of the concerns expressed by the Commission in the Robinson/Farewell report. Of greater concern however, was the lack of clear policy or training with respect to what is to be recorded in the cell log, when and by whom entries ought to be made, and with respect to the consistency of information to be logged.

10. FINDINGS AS TO THE CONDUCT OF THE NAMED OFFICERS AND THE APPROPRIATENESS OF THEIR ACTIONS IN THE SECOND COMPLAINT

Finding #12

The Commission finds that Corporal Hajash did not adequately check Mr. Keddie during his guardroom inspection on March 30, 1995.

The Commission further finds that, as a seasoned senior officer and having regard to his past knowledge of and personal experience with Mr. Keddie, Corporal Hajash had an opportunity and the responsibility to re-evaluate and reconsider the decision made by Constable Gibson to put Mr. Keddie in a cell. He failed to do so.

Finding #13

The Commission finds that Mr. Ken Armstrong was not provided with adequate training as an RCMP jail guard.

Finding #14

The Commission finds that on March 30, 1995 Mr. Armstrong failed to maintain an accurate and reliable log book pursuant to RCMP policy.

The Commission also notes that maintaining an accurate log may be a full-time job and may impose a responsibility that is impossible to meet under the present policy. Nevertheless, from the overall evidence adduced at the hearing, it is clear that the guard's log book is not accorded the required scrutiny or supervision by supervisors at the Whitehorse detachment.

Finding #15

The Commission panel feels unsettled about what Mr. Armstrong actually did on the night of March 30, 1995 regarding his duty to keep a close watch on Mr. Keddie. However, it finds that it cannot arrive at a determination on this issue because of a lack of conclusive evidence.

Finding #16

The Commission finds that Mr. Armstrong did not take appropriate action when he observed that Mr. Keddie was not breathing. This was obviously an emergency. He was required to sound the alarm and he failed to do so.

Finding #17

The Commission finds that Constable Conrod failed to respond appropriately to the first telephone call from Mr. Armstrong. Having regard to the kind of message he received from Mr. Armstrong, the Commission further finds that Constable Conrod should have attended in the cell block immediately.

Finding #18

The Commission finds that Constable Conrod failed in his duty as a superior officer by instructing Mr. Armstrong to go into the cell alone thereby placing Mr. Armstrong's safety in jeopardy. The Commission further finds that the actions of Constable Conrod were in direct contravention of RCMP policy.

Finding #19

The Commission finds that Constable Conrod responded appropriately to the second call from Mr. Armstrong. The Commission further finds that the evidence indicates Constable Conrod carried out his subsequent duties of caring for Mr. Keddie in a manner that would meet public expectations.

Finding #20

The Commission finds that, under the existing circumstances, Constable Rook acted properly and reasonably in removing Mr. Keddie from the cell to administer CPR safely. The Commission found no evidence that this officer failed in any responsibilities that he was required to carry out as a member of the Force.

Constable Rook's testimony and evidence from other witnesses confirmed that Constable Rook played a minor role in the events that transpired on the evening of March 30, 1995. Constable Rook started to perform CPR on Mr. Keddie and continued

to do so under difficult circumstances until the ambulance arrived at the hospital. In our view, this officer's conduct, without a doubt, met public expectations.

Finding #21

The Commission found no evidence that Constable Edmonds failed in carrying out any responsibilities related to the incidents that occurred on the evening of March 30, 1995.

11. RECOMMENDATIONS OF THE COMMISSION

1. We recommend that the RCMP, adopt and maintain a more appropriate and reliable system than the current one, by which policy and standards are set and maintained, especially where the care and custody of prisoners are concerned.
2. We recommend that RCMP training policies be reviewed and amended where necessary to ensure that RCMP officers are made fully aware of the common symptoms and signs or indicators that can occur in alcohol and drug abusers and receive training to learn to distinguish between these.
3. We recommend that all RCMP officers become familiar with the signs and symptoms of drug abuse and overdose and the ways in which drugs interact with alcohol. In addition, RCMP officers must receive refresher training in this area to keep them abreast of the rapid changes which occur as new drugs both legal and illicit are developed and find their way into our communities.
4. We recommend that the RCMP develop policy and procedures to ensure that trained professionals, including doctors and nurses, are available to assist RCMP officers in assessing the risk faced by persons arrested for intoxication or drug abuse.
5. RCMP officers must continue to receive first aid training and must maintain their proficiency in first aid skills through a process of retesting and requalification on a regular basis. The same care and attention must be paid to first aid qualifications as is paid to firearm and driving qualifications. A system of monitoring and testing qualifications must be designed and implemented to ensure that training and certification are maintained, that officers are advised when requalification is required and that timely action be taken to provide an opportunity for recertification.
6. We recommend that, under no circumstances, should any person arrested for public intoxication and suspected of being at risk to self or others be placed in a cell with another detained person.

7. We recommend that all cells in the Whitehorse RCMP detachment be monitored with a closed circuit audio visual system (CCTV) that is not only displayed at terminals in the cell area but also can be viewed by the operators in the telecommunications room. The CCTV system should have the capability of recording events with special care being taken to ensure that the audio visual records are properly secured to maintain the privacy of those arrested and incarcerated for any reason, (like a flight data recorder). Closed Circuit Television (CCTV) surveillance is meant to augment and not replace the need to regularly view all prisoners.
8. We recommend that the concept of community policing be re-examined in the context of drug and alcohol abuse and that a working partnership be struck with appropriate agencies and people in the community. This may require the RCMP to share some of the power and control they have traditionally exercised in these matters and lead to the sharing of the community policing process with others who are concerned and willing to become involved. This re-examination should provide the opportunity for all partners to:
 - a. evaluate the usefulness of the partnership on an ongoing basis;
 - b. determine the ways each can make the best contribution as a member of the team;
 - c. develop policy and procedures for dealing with alcohol abusers who come to their attention so that the reality that alcohol abuse is Yukon's most serious health problem can be addressed; and
 - d. formalize the partnership in a written agreement that should be attached to Detachment policy and available to RCMP officers as well as all participating partners. The contract should be reviewed from time to time and amended as the community changes and evolves.
9. We recommend that a comprehensive examination of the prerequisite qualifications, training, duties and responsibilities of civilian guards take place as soon as possible and that such a review consider at least the following:
 - a. the extent and quality of training received:
 - b. the feasibility and value of contracting out or assigning the duties performed by jail guards at the Whitehorse RCMP detachment to other qualified people or agencies that would have the sole responsibility to ensure the safe secure custody of prisoners;

- c. the purpose and value of the prisoner log or any other form of record keeping in light of the potential for such record keeping to interfere with the primary responsibility of the safety of persons in custody;
 - d. the value of supplementing direct observation of prisoners by guards using electronic audio visual equipment with a recording capability;
 - e. the need to develop communication protocols for emergencies so that the most timely response possible is made when the health of a person in custody is at risk in addition to ensuring that the safety of guards, officers and prisoners is not compromised; and
 - f. the need to have more than one person on duty at all times or in particular circumstances performing guard duties.
10. The mass of policy, administrative and operational, is so voluminous and difficult to access that the officers cannot become knowledgeable and remain current with it. We recommend that:
- a. a review of all policy in relation to the arrest, custody and care of intoxicated persons be undertaken to ensure that policy and procedures are clearly stated and consistent in every respect at all levels; and
 - b. the possibility be examined of providing RCMP officers with a pocket size operational policy manual so that officers have immediate access to all operating procedures including those regarding the arrest, custody and care of intoxicated persons (the Panel heard evidence of the value of such a pocket version of operational policy now in use by the police in Brandon Manitoba).
11. The Commission noted that the circumstances which gave rise to this Inquiry are remarkably similar to those in the Robinson/Farewell inquiry held by the Commission in British Columbia in 1989. Many of the recommendations arising out of that hearing are applicable to the circumstances and findings in this case. Those recommendations do not appear to have been incorporated into policy of the RCMP. Had those recommendations been implemented, Mr. Keddie might have had a better chance of survival. We have chosen to repeat some of the recommendations from that inquiry here in italics. We have underlined a few minor changes to make the recommendations accord with the circumstances of this Inquiry.
- "5.2 *The RCMP should ensure that all of its officers carrying out duties within Yukon recognize the responsibilities imposed on them when taking a person into custody under the authority of The Yukon Liquor Act. In particular, those officers must appreciate that they are subject to a*

statutory obligation to observe whether or not the person taken into custody is in need of remedial treatment by reason of the use of alcohol and, if so, that there is an obligation to take that person to a physician. With the increasing use of a variety of chemical substances in the general population, the significance of these responsibilities to the RCMP officer should be obvious. A complete and accurate record should be kept of the manner in which these responsibilities are fulfilled.

Of equal significance, the officer taking such person into custody should, at the earliest opportunity, determine whether or not there is an adult person who is willing and capable of taking charge of such person. If so, the adult person should be encouraged to do so rather than proceeding to place the intoxicated person in a cell. A record should be made of the efforts undertaken to find an adult willing and capable of accepting the responsibility for the care and custody of the intoxicated person.

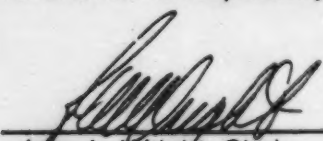
- 5.3 *When a person is taken into custody, whether by reason of intoxication or otherwise, the arresting officer must observe and record on the Prisoner Record the physical condition of the prisoner. The record itself is valuable, but even more valuable is the requirement on the part of the arresting officer to make the observation. Without this step being taken, the discharge of the duty of care becomes questionable.*
- 5.4 *Once a prisoner has been placed in a cell, frequent and accurate observations should be made of the activities and condition of the prisoner and a full record of such observations made by entry in the cell log or, if necessary, by supplemental report. If at any time it becomes necessary to remove a prisoner from the cell, such activity should only be carried out by two officers, an officer and one guard or by two guards. The time of removal should be entered in the cell log and a separate report made of the reason for such removal and any activity or occurrence which takes place while the prisoner is outside the cell. This report should be signed by both persons involved in the process. A notation should be made in the cell log of the time of the return of the prisoner to the cell.*
- 5.6 *The officer in charge of each Detachment should ensure that each officer and civilian guard reads and understands the RCMP operational manual and any Detachment supplement which pertains to the care and handling of persons in custody. Regular instruction should be instituted to ensure that this requirement is met. In the course of providing this instruction the officer in charge of the Detachment should obtain the assistance of qualified medical personnel who can instruct the officers and the civilian guards in the early recognition of signs and symptoms which, when exhibited by prisoners, indicate the need for medical assessment or assistance. Each officer or civilian guard should be aware of the*

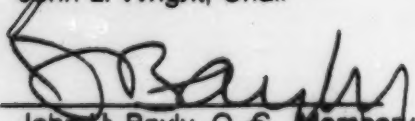
consequences of a combination of alcohol or substance abuse with or without a physical injury and the symptoms to be looked for. Periodically the officers and guards should be tested for their knowledge of and practical response to this aspect of custodial care.

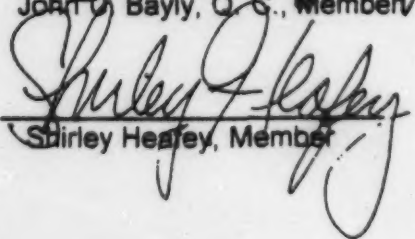
- 5.7 Each detachment should maintain a roster of the names and phone numbers of medical personnel available to serve the needs of the Detachment on a 24 hour basis.
- 5.8 *When the cells are occupied by more than one prisoner, the civilian guard should not be left on duty alone. In such circumstances, a second guard or an RCMP officer should remain in attendance at the detachment to assist in the event of any emergency."*
12. We recommend that the senior management of the RCMP at RCMP Headquarters in Ottawa review and monitor the extent to which it has implemented and continues to implement the recommendations contained in the reports of the Public Complaints Commission. The results of such a review and monitoring should be provided to the Solicitor General of Canada and the provincial and territorial ministers responsible for policing in the contracting jurisdictions. In addition, the RCMP should make the results of such review and monitoring available to the public, perhaps through the Force's annual public reports.
13. We recommend that the Commanding Officer of the Division responsible for the RCMP in the Yukon meet with the Yukon Minister of Justice to discuss the findings and recommendations of this Commission report and how the RCMP can more effectively deal with intoxicated persons under Yukon Legislation and policies.
14. We recommend that the Officer Commanding the Whitehorse Detachment of the RCMP meet with the Whitehorse City Mayor and Council to discuss the findings and recommendations of this Commission report and how the RCMP can more effectively deal with intoxicated persons under current policies and legislation.
15. We recommend that the Officer Commanding the Whitehorse Detachment of the RCMP meet with Ms. Donna Wilson to discuss the Commission's findings and recommendations and explain what steps will be taken to ensure the RCMP deal more effectively with intoxicated persons.
16. We recommend that the Commissioner of the RCMP write to the complainant, Ms. Donna Wilson, to:

- a. express regret over the tragic death of Mr Keddie while in the custody of the RCMP;
 - b. thank her, as a concerned citizen, for bringing forward the complaints concerning Mr Keddie's death which were aired before the Public Complaints Commission;
 - c. acknowledge that the senior management of the RCMP could have been more effective in developing policies and procedures and in ensuring that there was adequate training and supervision for dealing with prisoners who may have other potentially life threatening health problems when they are arrested and incarcerated in an intoxicated condition; and
 - d. state that the RCMP is committed to reviewing and improving its current policies, procedures, training and supervision concerning the arrest and incarceration of persons arrested for alcohol or drug abuse to ensure tragic events of this kind will not occur again.
17. We recommend that the Commissioner of the RCMP, if he has not already done so, write to Mr Keddie's next-of-kin expressing regret at Mr Keddie's tragic death while in the custody of the RCMP.

All of which is respectfully submitted this 31st day of January, 1997.



John L. Wright, Chair

John G. Bayly, Q. C., Member

Shirley Healey, Member

APPENDIX A

**APPENDIX A to
Wilson Complaint**

**ROYAL CANADIAN MOUNTED POLICE
PUBLIC COMPLAINTS COMMISSION**

ROYAL CANADIAN MOUNTED POLICE ACT, 1986

IN THE MATTER of a decision by the COMMISSION CHAIRMAN, having investigated in the public interest a complaint by Ms. Donna Wilson, to institute a hearing to inquire into the conduct of Constables Kevin Gibson, T.C. Parsons, D.B. Conrod, G.D. Rook, Brian Edmonds, Corporal B. Hajash and Mr. Kenneth Armstrong (guard) in the performance of their duties, namely:

On March 30, 1995 at the Whitehorse, Yukon RCMP Detachment, Mr. Robert Keddie died while in custody; he had been arrested at about 1730 hours for being drunk; at the time of Mr. Keddie's arrest, police were told by at least three people that Mr. Keddie had seizures; Mr. Keddie was also known to have a medical alert tag around his neck and around his wrist.

Mr. Keddie should have been taken to and checked at the hospital before being lodged in the Detachment and, there, he should have been adequately supervised because of his known medical condition; the complainant says that many members of the public are very concerned about this death at the RCMP Detachment. The named members and guard neglected their duties by failing to properly care for Mr. Keddie.

IN THE MATTER of an application by teleconference at 1800 hours Eastern Standard Time on 30 November, 1995 by Ms. Donna Wilson for the Commission to appoint and pay the costs of legal counsel to assist her in the course of the hearing.

PANEL (in Ottawa)

John U. Bayly, Q.C.	Member
Shirley Heafey	Member
John L. Wright	Chair

PARTIES AND COMMISSION COUNSEL (In Whitehorse)

Commission Counsel:	Mr. Ronald S. Veale
The Complainant:	Ms. Donna Wilson
For the named officers and guard:	Mr. E. Horembala
For the appropriate officer:	Mr. M. Florence

1. Ms. Wilson, in a letter dated 17 November, 1995, requested the Panel to appoint counsel to assist her in the course of the hearing pursuant to section 45.45(5) of the RCMP Act. Commission counsel, Mr. Veale arranged to have the application heard in a conference call. The parties sat together in Whitehorse with Commission Counsel while the three panel members sat together in Ottawa. The application including submissions from Ms. Wilson, Mr. Horembala, Mr. Florence and Mr. Veale, was heard at 1800 hours 30 November, 1995.
2. Ms. Wilson repeated the request she made in her letter and in particular emphasized that she had neither the knowledge of the process nor the skills necessary to adequately represent herself in the hearing and further she did not have the financial resources to pay for counsel.
3. Commission counsel stated that in his view Ms. Wilson was a party to the proceedings with a substantial and direct interest in this complaint before the Commission and that she must therefore be afforded a full and ample opportunity to present evidence, to cross-examine witnesses and to make representations at the hearing. Section 45.45(5) of the RCMP Act reads as follows:

"The parties and any other person who satisfies the Commission that the person has a substantial and direct interest in a complaint before the Commission shall be afforded a full and ample opportunity, in person or by counsel, to present evidence, to cross-examine witnesses and to make representations at the hearing."
4. Counsel for both the named officers and guard and the appropriate officer agreed that Ms. Wilson was a party to the proceedings. Counsel for the named officers and guard however stated that Ms. Wilson's concerns were public concerns and would more appropriately be represented by Commission Counsel. Further, he expressed concerns, arising out of her 17 November, 1995 letter, that Ms. Wilson was intending to either raise issues or enter evidence that may be neither relevant nor admissible. After some discussion with the Panel both counsel agreed that it would create an untenable situation for Commission counsel to be placed in a position of representing Ms. Wilson's personal interests to any extent that those interests did not coincide with the interests of the public. The Panel stated that counsel's concern about the admissibility and relevancy of Ms. Wilson's submissions, if any, would be subject to the standard tests of admissibility and relevance.
5. Pursuant to the provisions of section 45.35(1) of the RCMP Act, a member of the public who has a complaint about the conduct of a member of the RCMP or indeed

the conduct of any other person appointed or employed under the authority of the RCMP Act, may make a complaint to the Commission whether or not that member of the public is affected by the subject matter of the complaint. Ms. Wilson has stated in a letter to the Commission that she is not directly involved in the subject matter of the complaint and that she does not have a personal legal interest in the outcome. She was however a friend of the deceased and because of that her individual interest in the outcome may be more acute than that of members of the general public who were not acquainted with him. The fact that she is not affected by the subject matter of the complaint does not leave her without rights under the Act.

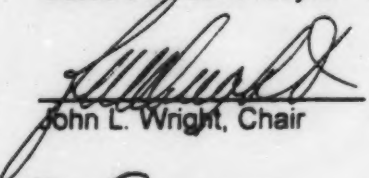
DECISION

6. The members of the panel concur with the positions of all counsel that Ms. Wilson has a substantial and direct interest in the complaint and therefore has the right to be represented by counsel if she chooses. We note this complaint is a complaint under section 45.35(1) of the Act and that the definition of parties in Section 45.46 of the Act clearly includes the complainant, in this case Ms. Wilson, as a party. The question the Panel is faced with is whether or not the Commission should pay for her counsel should she decide Commission counsel can not represent those interests and that she needs to retain her own counsel.
7. Ms. Wilson has not demonstrated that she has any financial, property, family or personal interest, other than the fact that she was a personal friend of the deceased Mr. Keddie, that would distinguish her interests in the outcome of the proceedings from those interests of the general public. She says she speaks for a small group of downtown residents however there is nothing in that claim that leads us to believe that the interests of that group are not included in those of the general public. In our view; Ms. Wilson's interests, the interests of the small group of downtown people she says she speaks for and the general public's interests are all the same and those are that the hearing process managed by the Panel be full, fair and open.
8. The decision of the Chairman of the RCMP Public Complaints Commission to hold this hearing was made pursuant to the terms of s. 45.43(1) of the RCMP Act. Under that section, the Chairman may order a hearing into a complaint where he considers it advisable in the public interest. He has done so in this case. The whole hearing is therefore to deal with the public interest in the circumstances surrounding the death of Mr. Keddie, which is the subject matter of the complaint. Commission counsel is responsible to ensure that all evidence relevant and in the public interest touching on the complaint be brought before us. Ms. Wilson's applications and submissions reveal

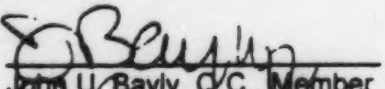
that her interest coincides with the public interest. It will be Commission counsel's responsibility to bring those public interests to the extent they are relevant, together with any other relevant public interests, before us and before the public in the hearings over which we will preside.

9. Accordingly it is our ruling that the Commission will not underwrite the costs of counsel to represent Ms. Wilson's interests in the public hearing to inquire into the circumstances touching on and surrounding the death of Robert Keddle. Ms. Wilson may choose to be represented by counsel or appear in person. If she chooses to be represented by counsel, she will have to find the resources from another source.
10. Finally, as to our statutory authority to provide for and underwrite the legal fees of a complainant or any other person appearing as a party before the commission, we make no ruling at this time. If we have that authority we have decided not to exercise it in this case for the reasons we have stated.

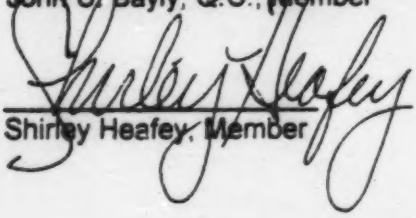
Dated this 22nd day of January, 1996.



John L. Wright, Chair

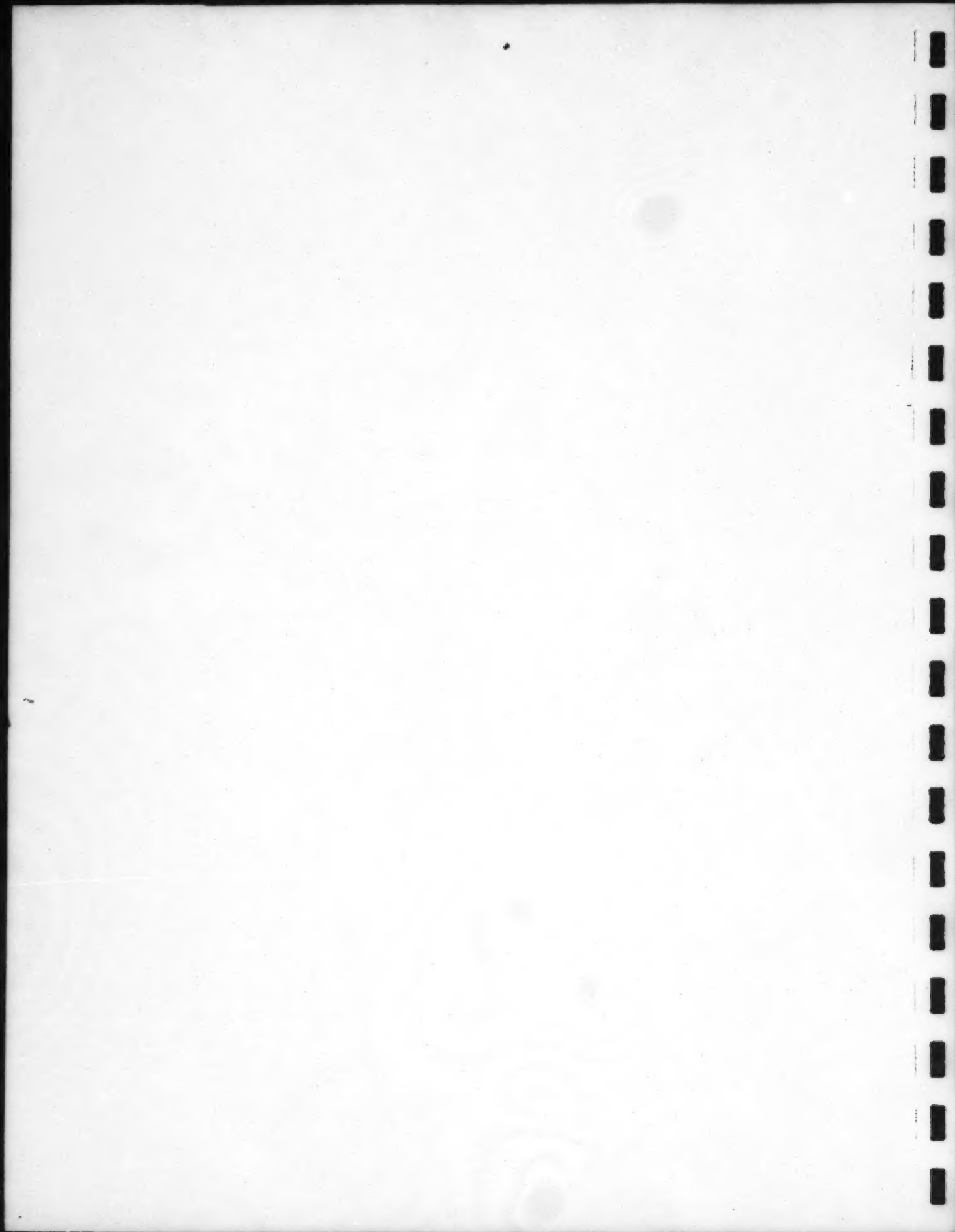


John U. Bayly, Q.C., Member



Shirley Heafey, Member

APPENDIX B



Royal Canadian Mounted Police



Gendarmerie royale du Canada

J.P.R. Murray
Commissioner Le Commissaire

November 21, 1997

PROTECTED "A"

Ms. Shirley Heafey
Chair
RCMP Public Complaints Commission
P.O. Box 3423
Station "D"
Ottawa, Ontario
K1P 6L4

Dear Ms. Heafey:

I acknowledge receipt of the Commission's interim report of February 26, 1997, file reference 2000-PCC-950295, and materials relevant to the complaint of Ms. Donna Wilson.

On October 19, 1997, the findings and recommendations of the Commission Panel were examined and the following notice is provided pursuant to the Royal Canadian Mounted Police Act.

Following my thorough examination of all the facts and evidence available in this case, I have little difficulty in supporting the recommendations advanced by the Commission Panel's interim report. You will find my comments on individual recommendations further in this report.

Although I concur with the majority of the findings, I do have difficulty with a few of them and I will attempt to comment individually on those that are of concern.

First of all, in analysing a case such as this, one must always attempt to look at it in proper perspective, particularly when evaluating the reaction of individual police personnel faced with such incidents and the need to quickly analyse the situation, make on the spot decisions, and react appropriately in line with their assessment of the situation.

.../2

One must not overlook the fact that although there is evidence in this case that Mr. Keddie was prone to having seizures or heart attacks, there is considerably less specific evidence that Mr. Keddie was having such a seizure or heart attack on the night in question when he was in the care of RCMP members. In the end, the pathologist in his evidence indicates that Mr. Keddie did not have a heart attack nor was there evidence that he had suffered a seizure of any kind. The cause of death was an acute level of morphine and alcohol in his blood.

Having said this, I will briefly comment on individual findings.

Finding 1: I agree with your finding.

Findings 2 and 3: Although I do not find the evidence as compelling and conclusive as indicated in these two findings, I agree that the two arresting officers could have interpreted and reacted differently to the indicators that they encountered and considered during this incident.

The evidence has, however, not convinced me that they neglected or ignored such indicators. Evidence shows that the sobriety of some of the witnesses was questionable. Arresting officers based their decisions on their immediate observations, knowledge of the individuals involved, and past experience. This does not, however, alter their apparent lack of sufficient knowledge and up to date training in the handling of intoxicated people according to RCMP policy, as indicated in finding 8.

Finding 4: I agree with your finding.

Finding 5: I agree with the finding that there was no evidence to reveal the existence of "conclusive indicators" that could have led the two arresting members to suspect Mr. Keddie was a victim of a drug overdose. Although Constable Parsons did have training in making observations and in recognizing indicators of drug abuse or overdose, this did not include opiates (heroin and morphine). Evidence shows that the only factor that could have assisted our members is the "pin-point" pupils.

Finding 6: Similarly, in this finding, it is a matter of interpretation of indicators as to the existence of a drug overdose, an acute alcohol poisoning, total drunkenness, a seizure or a heart attack. The only conclusive real evidence is that of the pathologist.

Finding 7: The Commission finds that Mr. Keddie was not fully conscious and consequently, should have been taken to the hospital. Yet evidence shows that, although his words were slow, Mr. Keddie could converse with Mr. Gillingwater. Mr. Keddie acknowledged Constable Parsons' presence by saying "Hey Natz". A fellow detainee in the back of the police vehicle indicated that Mr. Keddie knew where he was going by stating "Here we go again". Evidence from both officers reveals that, in the detachment cells, during the process of searching Mr. Keddie, he tried to sit up on two occasions. As a result, one could as easily conclude that Mr. Keddie was grossly intoxicated but nonetheless conscious.

Finding 8: The findings of the Commission are appropriate considering the vagueness of the members' testimonies in interpreting policy and their lack of knowledge and understanding of existing policy directives.

Finding 9: I agree with this finding. The C-13 form and bulk filing system does not adequately deal with high risk prisoners. Additional precaution must be taken with prisoners who are dangerous, suicidal or who have serious health problems.

Finding 10: I agree with the Commission's finding. Whitehorse Detachment policy directives acknowledgement systems appear to be absent.

Finding 11: I agree with the Commission's finding. There is evidence of a lack of policy knowledge and interpretation in the members' testimonies. It is the responsibility of the supervisors to ensure that this deficiency does not exist and to provide appropriate guidance.

Finding 12: This finding again deals with the interpretation and evaluation of indicators by an experienced police officer. Although the Commission found Corporal Hajash was complacent, lacked awareness and

alertness vis-à-vis his responsibility for the treatment of a prisoner in his care, evidence indicates that Mr. Keddie was already asleep in the cell when the Corporal started his shift. He spoke with Constable Gibson and was made aware of the circumstances surrounding the arrest, including his proneness to seizures. He then proceeded to review the C-13 form and to speak to Mr. Armstrong, the cell guard. He then checked cell #7 where he found Mr. Keddie lying down with his head directly in front of the cell door. He asked whether Mr. Keddie had been placed in this position and was informed that the prisoner had been placed against the wall but had turned around 180 degrees since his incarceration. He further bent down towards Mr. Keddie's head to satisfy himself that the prisoner was in fact breathing. Mr. Keddie let out a big snore which would indicate that he was sleeping. He further asked Mr. Armstrong to keep a close eye on the prisoner. Unfortunately in some of these incidents, previous knowledge of a certain prisoner's history and habits can indeed affect one's interpretation and conclusion. This is why I cannot totally agree with the Commission's conclusion.

Findings 13 and 14: I agree with the Commission's finding that Mr. Armstrong was not provided with adequate training and that he failed to maintain an accurate and reliable log book. Obviously, Mr. Armstrong should not have let his First-Aid/CPR certificate expire and he should have been better informed with regards to unit supplements dealing with his specific duties. I also agree that supervisors did not scrutinize the log book appropriately.

Finding 15: This finding is understandable under the circumstances. There is no need for me to comment further.

Finding 16: I agree that Mr. Armstrong did not follow directives and should have sounded the alarm immediately.

Findings 17, 18, 19, 20 and 21: I agree with these findings.

I will now deal with each of the recommendations.

Recommendation 1: It appears obvious that detachments', divisions' and Headquarters' policy regarding the care and

handling or custody of prisoners is not consistent. This area must be reviewed by responsibility centres and this review should be conducted with the assistance of medical professionals.

Recommendations 2 and 3: Although Cadet training appears to cover most if not all the areas of concern raised by the Commission, there appears to be a lack of in-service refresher training in this area. This topic should be reviewed at both national and divisional levels and appropriate amendments should be put in place to ensure that members are properly informed and kept up-to-date on this critical subject.

Recommendation 4: National policy should direct that all cell accommodations have this sort of professional information and procedures in place to gain assistance and this information should also be included in unit supplements.

Recommendation 5: I fully agree with this recommendation. The Commanding Officer must not only ensure that all operational members are qualified in First-Aid/CPR, but must also ensure that their certificates are maintained according to national policy requirements.

Recommendation 6: I am unable to totally agree with this recommendation. Although I agree that the risk to self or others must be considered thoroughly when deciding to place an intoxicated person in a cell with another detainee, it would be unrealistic and would not be enforceable to completely forbid this practice. Policy should deal with the evaluation of the risk and the decision should be made by the officer responsible.

Recommendation 7: I agree that closed circuit television surveillance is an added tool meant to augment and not to replace the need to regularly view all prisoners. Such equipment should be utilized in all cell areas where required, practical and feasible.

Recommendation 8: Community policing is an approach and philosophy that I strongly support. However, writing community policing into policy may not be the best way to proceed. The Commanding Officer, who has overall

responsibility for the implementation of community policing should ensure that community partnerships are developed with appropriate agencies and with the community. He should offer to share some of the community policing problems with those that are willing to become involved. Special attention should be paid to sharing problem-solving responsibilities, particularly on socially-oriented issues such as alcohol and drug abuse. Community involvement should be an ongoing exercise in order that changing trends and times reflect partnership efforts and programs.

Recommendation 9: Considering the number of issues surfaced in this case, I agree that the Commanding Officer should carry out a comprehensive examination of the prerequisite qualifications, training, duties and responsibilities of civilian guard systems in his division. It appears that many of the shortcomings identified are in fact already addressed in national policy. The Commanding Officer is to ensure that shortcomings and other issues identified by the Commission Panel are corrected.

Recommendation 10: This recommendation can be addressed with recommendations 2 and 3. I agree that the amount of policy now in place is cumbersome and is difficult for the members themselves to keep up-to-date. In light of new and evolving technologies, the Director of Community, Contract and Aboriginal Policing is to review and examine means of reducing and streamlining policy dealing with the care, handling and custody of intoxicated persons. The Commanding Officer of "M" Division is to ensure that all supervisors responsible for the care and custody of intoxicated persons are aware of policies and have a method of recording and ensuring that their subordinates are informed of changes as they occur.

Once this sort of policy information system is in place, the need for a pocket-size operational manual is eliminated.

Recommendations 11 and 12: I agree that the RCMP must have a method of monitoring and reporting the implementation of the RCMP Public Complaints Commission's recommendations. It would appear that some of the previous 1989 Robinson/Farewell Commission's recommendations were not

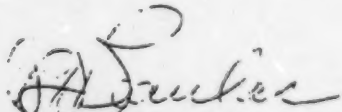
implemented. The Officer in charge of the External Review and Appeals Section is to follow-up on this and to ensure that appropriate action is taken in line with my instructions. The results are to be reported to the Solicitor General of Canada in the usual fashion.

Recommendations 13 and 14: I agree with this recommendation and I will instruct the Commanding Officer of "M" Division to ensure that these recommendations are carried out, if he has not already done so. He must reassure these community leaders that the Commission's recommendations are taken seriously and that corrective action is taken when required.

Recommendations 15, 16 and 17: Existing policy requires that all complainants be informed, to the extent possible, of the results of their expressed complaints and/or concerns. In this case, the Commanding Officer should take the opportunity to meet with Ms. Donna Wilson to express the RCMP's regret over the death of Mr. Keddie while in the RCMP's custody, thank her for bringing her complaint forward and state that the RCMP is committed to reviewing and to improving its current policies, training and supervision concerning the arrest of intoxicated persons by alcohol or drugs. The same form of regret and commitment should be expressed to the next of kin by the Commanding Officer.

I thank the Panel for their advice and I look forward to receiving your final report.

Sincerely,



J.P.R. Murray

John P. Murray